

## 11672 CERTIFICATE OF DEATH

11597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT of Columbia</b> b. COUNTY <b>NONE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS A.F. BASE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 20, D.C. 47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL, ANDREWS</b>				d. STREET ADDRESS <b>1621 RIDGE PLACE S.E.</b>			
3. NAME OF DECEASED (Type or print) 1 First Middle Last <b>FRANK M. AARON</b>				4. DATE OF DEATH Month Day Year <b>OCT 13 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 13 1958</b>	9. AGE (In years lost birthday) yrs. <b>—</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>— — — 2</b>	IF UNDER 24 HRS. Hours Min. <b>— —</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES H. AARON</b>				14. MOTHER'S MAIDEN NAME <b>INEZ C. WALKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>FATHER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, neonatal death</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>13 OCTOBER, 1958</b> , to <b>13 OCTOBER, 1958</b> , that I last saw the deceased alive on <b>13 OCTOBER, 1958</b> , and that death occurred at <b>1:02 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>130CT58</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Richard J. Hattup</b> M.D.				ADDRESS <b>USAF HOSPITAL, ANDREWS A.F.B. MD.</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD J. HATTUP CAPTMC USAF HOSPITAL, ANDREWS A.F.B. MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GOLDEN GATE NATL. CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SAN FRANCISCO, CALIFORNIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Washington, D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 17 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

2150285XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12/5/28	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION None	
11. PRESENT ADDRESS Room 106, 535 North Dearborn St., Chicago, Ill.		12. DATE OF DEATH 4/4/68	
13. PLACE OF DEATH Chicago, Ill.		14. CAUSE OF DEATH Suicide	
15. MANNER OF DEATH Suicide		16. SIGNATURE OF PHYSICIAN [Signature]	
17. SIGNATURE OF REGISTRAR [Signature]		18. SIGNATURE OF WITNESS [Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, § 1-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, § 1-102.

## CERTIFICATE OF DEATH

11598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>NONE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS A.F. BASE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 20, D.C.</u> 47X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL, ANDREWS</u>				d. STREET ADDRESS <u>1621 RIDGE PLACE S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GLENN H. AARON</u>				4. DATE OF DEATH Month Day Year <u>OCT 13 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 13 1958</u>	
9. AGE (In years lost birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>		IF UNDER 24 HRS. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES H. AARON</u>				14. MOTHER'S MAIDEN NAME <u>INEZ C. WALKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u> (If yes, give war or dates of service) <u>N/A</u>				16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>FATHER</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth, neonatal death</u> 2 MINU 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 OCTOBER 1958</u> to <u>13 OCTOBER 1958</u> , that I last saw the deceased alive on <u>13 OCTOBER 1958</u> , and that death occurred at <u>3:17 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1300158</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Richard J. Hattrup</u> USAF Hospital, Andrews A.F.B. Md.							
PHYSICIAN'S NAME (Type) <u>RICHARD J. HATTRUP CAPT USAMEC USAF Hospital, Andrews A.F.B. Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-17-58</u>		<u>GOLDEN GATE NATL CEM</u>		<u>SAN FRANCISCO CALIFORNIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2250286XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# Item 8 Form 23-11-3-58 et 11674 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7609 WALTERS LANE</u>		d. STREET ADDRESS <u>7609 WALTERS LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARY</u> Last <u>ALLEN</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>22ND</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1885 JULY 9</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER GRAMMICK</u>		14. MOTHER'S MAIDEN NAME <u>DORA KLUG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MABEL E. DILLARD</u> Address <u>1704 16TH ST. S.E. WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> (c) <u>and Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15, 1958</u> , to <u>Oct 22, 1958</u> , that I last saw the deceased alive on <u>Oct 21, 1958</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u>		ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington 28 DC</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN Natta</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATL.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITHLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlain</u> ADDRESS <u>517 11th St S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. W. Chamberlain</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11616

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 11600

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 MT RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4109 29TH ST.</u>		d. STREET ADDRESS <u>4109 29TH ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Auguste</u> Middle <u>Anderson</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27 1897</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Auguste Kohl</u>		14. MOTHER'S MAIDEN NAME <u>Dorothea Dietrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helene A. Vikingstad</u> Address <u>4109 29TH ST MT RAINIER MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>8 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1956</u> , to <u>OCT 23, 1958</u> , that I last saw the deceased alive on <u>OCT 23, 1958</u> , and that death occurred at <u>11:22 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comen</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 PERRY ST</u> DATE SIGNED <u>10/24/58</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEN</u>		<u>MT. RAINIER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>10/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc.</u> ADDRESS <u>MT. RAINIER, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR <u>OCT 28 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARJUNO STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11601

Reg. Dist. No.

11601

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Prince Georges</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Pr. Geo.</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Hyattsville</span>			c. LENGTH OF STAY IN lb <span style="font-size: 1.2em;">3 weeks</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">15 Hyattsville</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">4717 Baltimore Avenue</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">4717 Baltimore Avenue</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Morris Edwin Anglin</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">October</span> Day <span style="font-size: 1.2em;">29</span> Year <span style="font-size: 1.2em;">19 58</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">October 21, 1905-53</span> yrs.	
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">53</span> yrs.		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;"> </span> Days <span style="font-size: 1.2em;"> </span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;"> </span> Min. <span style="font-size: 1.2em;"> </span>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Proof reader</span>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Newspaper</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Washington, D.C.</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Henry Anglin</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Susan Morriss</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No.</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;"> </span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">5604 Longfellow Street, Mildred Anglin; Hyattsville, Maryland</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Pulmonary embolism</span>  <b>491X</b> DUE TO          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="font-size: 1.2em;">Bronchopneumonia</span>  <b>491X</b> DUE TO       </div> <div style="width: 35%; border: 1px solid black; padding: 5px;">         INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;"> </span> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="font-size: 1.2em;">19</span> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">John T. Maloney</span>				<b>DATE SIGNED</b> <b>October 29, 1958</b>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">John T. Maloney, M.D.</span>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Entombment</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Nov 1, 1958</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Fort Lincoln Masoleum</span>		<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Colmar Manor, Md.</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">F. Gasch's Sons</span>				<b>ADDRESS</b> <span style="font-size: 1.2em;">Hyattsville Md.</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">NOV 3 58</span>	
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;"> </span>				<b>24c. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;"> </span>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 11624 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>2900 R.I. Ave N. E.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH <b>Oct.</b> Month <b>27</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1876</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Appleman</b>		14. MOTHER'S MAIDEN NAME <b>Rachel H. Gilbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>2900 R.I. Ave Washington, D.C.</b>	
17. INFORMANT <b>Sister</b> <b>Branda Walton</b>		Address <b>2900 R.I. Ave Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE INFARCTS TO SPLEEN, LIVER, LUNGS</b> / <b>1 WK</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUBACUTE BACTERIAL ENDOCARDITIS</b> / <b>1 mos</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 19</b> , 19 <b>56</b> to <b>OCT 27</b> , 19 <b>58</b> that I last saw the deceased alive on <b>OCT 27</b> , 19 <b>58</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Norman D. Comeau</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Norman D. Comeau</b> <b>3503 Perry St., Mt. Rainier, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
		<b>10/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Greenwood</b>		<b>La Grange, Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home, Inc.</b> <b>Mt. Rainier, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

DATE

1925

DECEASED

NAME

JOHN J. HARRIS

AGE

65

SEX

Male

RESIDENCE

1000 N. E. ST.

CITY

DECEASED

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

1925

PLACE OF DEATH

HOME

SIGNATURE OF DECEASED

1925

DATE OF DEATH

1925

PLACE OF DEATH

HOME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11625 CERTIFICATE OF DEATH

12797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>				c. LENGTH OF STAY IN 1b <u>9 hrs 50 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Arnett "A"</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 19, 1958</u>	
9. AGE (In years last birthday) yrs. <u>9</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Alfred</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Belt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Henrietta Arnett Mother</u>				Address <u>Address Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>October 19, 19 58</u> , to <u>October 20, 19 58</u> , that I last saw the deceased alive on <u>October 20, 19 58</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Rubin</u>				DATE SIGNED <u>10/24/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamilton H., Hyattsville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>11/11/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital, Beverly, Md.</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Immediate cause: _____</p>		<p>9. Underlying cause: _____</p>	
<p>10. Manner of death: _____</p>		<p>11. Signature of physician: _____</p>		<p>12. Signature of registrar: _____</p>	
<p>13. Date of registration: _____</p>		<p>14. Office of registration: _____</p>		<p>15. District of registration: _____</p>	
<p>16. Name of informant: _____</p>		<p>17. Address of informant: _____</p>		<p>18. Telephone number: _____</p>	
<p>19. Name of informant: _____</p>		<p>20. Address of informant: _____</p>		<p>21. Telephone number: _____</p>	
<p>22. Name of informant: _____</p>		<p>23. Address of informant: _____</p>		<p>24. Telephone number: _____</p>	
<p>25. Name of informant: _____</p>		<p>26. Address of informant: _____</p>		<p>27. Telephone number: _____</p>	
<p>28. Name of informant: _____</p>		<p>29. Address of informant: _____</p>		<p>30. Telephone number: _____</p>	
<p>31. Name of informant: _____</p>		<p>32. Address of informant: _____</p>		<p>33. Telephone number: _____</p>	
<p>34. Name of informant: _____</p>		<p>35. Address of informant: _____</p>		<p>36. Telephone number: _____</p>	
<p>37. Name of informant: _____</p>		<p>38. Address of informant: _____</p>		<p>39. Telephone number: _____</p>	
<p>40. Name of informant: _____</p>		<p>41. Address of informant: _____</p>		<p>42. Telephone number: _____</p>	
<p>43. Name of informant: _____</p>		<p>44. Address of informant: _____</p>		<p>45. Telephone number: _____</p>	
<p>46. Name of informant: _____</p>		<p>47. Address of informant: _____</p>		<p>48. Telephone number: _____</p>	
<p>49. Name of informant: _____</p>		<p>50. Address of informant: _____</p>		<p>51. Telephone number: _____</p>	
<p>52. Name of informant: _____</p>		<p>53. Address of informant: _____</p>		<p>54. Telephone number: _____</p>	
<p>55. Name of informant: _____</p>		<p>56. Address of informant: _____</p>		<p>57. Telephone number: _____</p>	
<p>58. Name of informant: _____</p>		<p>59. Address of informant: _____</p>		<p>60. Telephone number: _____</p>	
<p>61. Name of informant: _____</p>		<p>62. Address of informant: _____</p>		<p>63. Telephone number: _____</p>	
<p>64. Name of informant: _____</p>		<p>65. Address of informant: _____</p>		<p>66. Telephone number: _____</p>	
<p>67. Name of informant: _____</p>		<p>68. Address of informant: _____</p>		<p>69. Telephone number: _____</p>	
<p>70. Name of informant: _____</p>		<p>71. Address of informant: _____</p>		<p>72. Telephone number: _____</p>	
<p>73. Name of informant: _____</p>		<p>74. Address of informant: _____</p>		<p>75. Telephone number: _____</p>	
<p>76. Name of informant: _____</p>		<p>77. Address of informant: _____</p>		<p>78. Telephone number: _____</p>	
<p>79. Name of informant: _____</p>		<p>80. Address of informant: _____</p>		<p>81. Telephone number: _____</p>	
<p>82. Name of informant: _____</p>		<p>83. Address of informant: _____</p>		<p>84. Telephone number: _____</p>	
<p>85. Name of informant: _____</p>		<p>86. Address of informant: _____</p>		<p>87. Telephone number: _____</p>	
<p>88. Name of informant: _____</p>		<p>89. Address of informant: _____</p>		<p>90. Telephone number: _____</p>	
<p>91. Name of informant: _____</p>		<p>92. Address of informant: _____</p>		<p>93. Telephone number: _____</p>	
<p>94. Name of informant: _____</p>		<p>95. Address of informant: _____</p>		<p>96. Telephone number: _____</p>	
<p>97. Name of informant: _____</p>		<p>98. Address of informant: _____</p>		<p>99. Telephone number: _____</p>	
<p>100. Name of informant: _____</p>		<p>101. Address of informant: _____</p>		<p>102. Telephone number: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12798

## 11626 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b X Cedar Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 6438 H Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Arnett "B"		4. DATE OF DEATH Month Day Year Oct. 20 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.B.		10b. KIND OF BUSINESS OR INDUSTRY Newborn	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Arnett		14. MOTHER'S MAIDEN NAME Henrietta Belt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Henrietta Belt Arnett	
17. INFORMANT Henrietta Belt Arnett		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Atelctasis Prematurity</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19, 1958, to Oct. 20, 1958, that I last saw the deceased alive on Oct. 20, 1958, and that death occurred at 9:00 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Dr. John W. Perkins		DATE SIGNED 10/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/11/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR DATE NOV 13 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11627 CERTIFICATE OF DEATH

11603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Baumann</b> Last <b>Baumann</b>				4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 17, 1875</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Baumann</b>				14. MOTHER'S MAIDEN NAME <b>Eva Tries</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>491X</b> (b) <b>Cerebral thrombosis</b> DUE TO <b>1 wk</b> (c) <b>Diabetes Mellitus</b> <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic Cardio-Vascular Dis -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>10 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10/11</b> 19 <b>48</b> to <b>10/13/58</b> that I last saw the deceased alive on <b>10/13/58</b> 19 <b>58</b> and that death occurred <b>10/13/58</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J M Warren</b>				DATE SIGNED <b>Laurel Md 10/13/58</b>			
PHYSICIAN'S NAME (Type) <b>John M. Warren M.D.</b>				<b>305 Prince George Street, Laurel, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of Ascension</b>		22d. LOCATION (City, town, or county) (State) <b>Bowie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Harsch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 15 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

## MAY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11675 CERTIFICATE OF DEATH

11604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geor's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TEMPLE HILLS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TEMPLE HILLS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4560 ST. BARNABAS RD</u>				d. STREET ADDRESS <u>4560 - ST. BARNABAS RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD LEE BEALL</u>				4. DATE OF DEATH Month Day Year <u>OCT 11 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 4 - 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Gov</u>		11. BIRTHPLACE (State or foreign country) <u>CLINTON, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOSHUA BEALL</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA SMALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>MRS Medora F. Beall as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas with metastases</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>58</u> , to <u>10/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>58</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lynn</u> M.D.				ADDRESS (Street, city or town, state) <u>5241 St. Barnabas Rd</u>			
DATE SIGNED <u>10/11/58</u>				PHYSICIAN'S NAME (Type) <u>JOHN T. LYNN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>OCT 14 - 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas</u>		22d. LOCATION (City, town, or county) (State) <u>Oror Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Linn Bros</u> ADDRESS <u>1661 - 4th Ave Rd</u>				24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

\_\_\_\_\_

11602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington, DC 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor, 4922 DaSalle Ave.		d. STREET ADDRESS 7316 Alaska Ave. NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED MARY First MARGARET Middle BEITZELL Last		4. DATE OF DEATH Month Oct. 12 Day Year 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1874	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Cumberland CUMBERLAND		14. MOTHER'S MAIDEN NAME Mary V. Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mary Louise Beitzell 7316 Alaska Ave. N.W. Wash. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cardiac arrest DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Oct 12, 1958, that I last saw the deceased alive on Oct 12, 1958, and that death occurred at 9:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) 5415 Conn Ave	
PHYSICIAN'S NAME (Type) James Edward Fitzgerald, M.D.		DATE SIGNED 10/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Wash. DC	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 1756 Pa. Ave. NW DC		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
		24b. REGISTRAR'S SIGNATURE [Signature]	

366 EL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11606

## 11628 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>5 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arden</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>1152 5th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>Bell</b> Last <b>Bell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Oct. 1958</b>		9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Louis Bell</b>				14. MOTHER'S MAIDEN NAME <b>Helen Joyce Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>abnormal pulmonary condition</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>fractured (3 lbs)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>both on</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>3,25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas A. Christensen</b> M.D. <b>College Park, Maryland 10/2/58</b> PHYSICIAN'S NAME (Type) <b>Dr. J Perkins, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>10-6-58</b>		<b>10-6-58</b>		<b>Woodmore Cem.</b>		<b>Woodmore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Worthington &amp; Davis NW</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	

2077182 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11028 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 15 1915		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 15 1850		BALTIMORE, MARYLAND		JAN 15 1880	
FATHER'S NAME		MOTHER'S NAME		EDUCATION	
JAMES HARRIS		MARY HARRIS		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT	
NONE		PAIN IN CHEST		NONE	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY	
JAN 16 1915		BALTIMORE, MARYLAND		NONE	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9, Film G234, 10/10/58  
Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

11607

11629

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>41 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deedar Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>904 64th Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Bell</b> Last <b>Bell</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-8-77</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Macon, Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Franklin Bell</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Northen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Born Chapman pneumonia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hyper tensive Arterio Sclerosis H.D. on 58y.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>8-22-1958</b> , to <b>10-1-1958</b> , that I last saw the deceased alive on <b>10-1-1958</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Norman Donat Comeau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St</b>		DATE SIGNED <b>10/2/58</b>	
PHYSICIAN'S NAME (Type) <b>Norman Donat Comeau</b>		<b>MT Rainier Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-6-58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>4611-Berningrd, N.E.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. S. Washington</b>		ADDRESS <b>467-77 St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 58</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. P. ...</b>					

508

EX-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11608

11676 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>			d. STREET ADDRESS <u>1673 Columbia Rd., N. W.</u>		
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>Leroy</u> Last <u>Belleman</u>			4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/91</u>		9. AGE (In years last birthday) yrs. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired from government</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>Jerry A. Belleman</u>			14. MOTHER'S MAIDEN NAME <u>Luella Victoria Whitman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>9/18 - 8/19</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Decedent</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, postoperative</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis, 9 months; rt., lumbar sympathectomy, 10/17/58</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/29</u> , 19 <u>58</u> , to <u>10/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>58</u> , and that death occurred at <u>11:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> <u>10/17/58</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL, ETC. <u>REMOVED</u>	22b. DATE THEREOF <u>10/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>-</u>		22d. LOCATION (City, town, or county) (State) <u>Miamisburg, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>		ADDRESS <u>117 S. Spring St.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



11630

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>4710 Nan-tucket Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Blom), Ethel May Blom</u>				4. DATE OF DEATH Month Day Year <u>10 23 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-19-1898</u>	
9. AGE (In years lost birthday) <u>60 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Day</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter - Dorothy L. Linton</u>		Address <u>5023 College Park, Md.</u> <u>4710 Nan-tucket Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis left Lenticulo-striate artery</u> <u>454X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>auricular fibrillation, Cardiac decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 2 wks</u> <u>year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-15-58</u> , 19 <u>58</u> , to <u>10-23-58</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>10-23-58</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Weintraub</u>		M.D. <u>30 C Ridge Rd, Brentsville, Md</u>		ADDRESS (Street, city or town, state) <u>30 C Ridge Rd, Brentsville, Md</u>		DATE SIGNED <u>10-23-58</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM C. WEINTRAUB</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11650

Reg. Dist. No.

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration			
JAMES H. HARRIS		Male		White		1890		Maryland		Baltimore		1910		Baltimore		Heart Disease		Natural		J. H. Harris		J. H. Harris		1910			
14. Signature of informant		15. Informant's name		16. Informant's address		17. Informant's occupation		18. Informant's relationship to deceased		19. Informant's signature		20. Informant's name		21. Informant's address		22. Informant's occupation		23. Informant's relationship to deceased		24. Informant's signature		25. Informant's name		26. Informant's address		27. Informant's occupation	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

TO BE FILLED BY THE REGISTRAR

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Place of death

9. Cause of death

10. Manner of death

11. Signature of physician

12. Signature of registrar

13. Date of registration

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11677

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penn-Railroad Station				d. STREET ADDRESS 297-Jencho Park Road			
3. NAME OF DECEASED (Type or print) Floyd Ravasser Bonner				4. DATE OF DEATH 10-22-1958			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-15	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fabricating equipment U.S. Govt				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt			
11. BIRTHPLACE (State or foreign country) N. Carolina				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME James Edward Bonner				14. MOTHER'S MAIDEN NAME Ann Etta Gathier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Queen S Bonner, Bonner Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & shock 810X DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma—multiple & severe. (c) DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an auto. struck by a Penn R.R. Train			
20c. TIME OF INJURY Month, Day, Year 10-22-1958				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) P.R. Tracks				20f. (City or town) Bowie, Pr. Geo. Md (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN T. MALONEY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-22-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose B. Boyd				ADDRESS 1738-20 St NW			
24a. REC'D BY REGISTRAR OCT 24 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1101

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1187

17  
DEATH  
CERTIFICATE

*[Faint, mostly illegible handwritten text and stamps are visible across the form, including names and dates.]*

☐ Cause of death is a disease of the heart  
☐ Cause of death is a disease of the lungs  
☐ Cause of death is a disease of the stomach and intestines  
☐ Cause of death is a disease of the liver  
☐ Cause of death is a disease of the kidneys  
☐ Cause of death is a disease of the brain  
☐ Cause of death is a disease of the nerves  
☐ Cause of death is a disease of the blood  
☐ Cause of death is a disease of the skin  
☐ Cause of death is a disease of the bones  
☐ Cause of death is a disease of the muscles  
☐ Cause of death is a disease of the joints  
☐ Cause of death is a disease of the sense organs  
☐ Cause of death is a disease of the reproductive organs  
☐ Cause of death is a disease of the endocrine system  
☐ Cause of death is a disease of the immune system  
☐ Cause of death is a disease of the circulatory system  
☐ Cause of death is a disease of the respiratory system  
☐ Cause of death is a disease of the digestive system  
☐ Cause of death is a disease of the urinary system  
☐ Cause of death is a disease of the excretory system  
☐ Cause of death is a disease of the integumentary system  
☐ Cause of death is a disease of the skeletal system  
☐ Cause of death is a disease of the muscular system  
☐ Cause of death is a disease of the nervous system  
☐ Cause of death is a disease of the endocrine system  
☐ Cause of death is a disease of the immune system  
☐ Cause of death is a disease of the circulatory system  
☐ Cause of death is a disease of the respiratory system  
☐ Cause of death is a disease of the digestive system  
☐ Cause of death is a disease of the urinary system  
☐ Cause of death is a disease of the excretory system  
☐ Cause of death is a disease of the integumentary system  
☐ Cause of death is a disease of the skeletal system  
☐ Cause of death is a disease of the muscular system  
☐ Cause of death is a disease of the nervous system

## 11617 CERTIFICATE OF DEATH

Reg. Dist. No. 11611

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4101-29th Street</u>				d. STREET ADDRESS <u>4101-29th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICK JOSEPH BOYLE</u>				4. DATE OF DEATH Month Day Year <u>October 7 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MINER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Broadford, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Boyle</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Walsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>167-09-0729</u>		17. INFORMANT <u>James F. Boyle</u> Address <u>4101-29th St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERAL</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>(MORE THAN FILE)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>11 AM</u> , 19 <u>53</u> , to <u>OCTOBER 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>OCTOBER 6</u> , 19 <u>58</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u>				ADDRESS (Street, city or town, state) <u>1034 PERRY ST., N.E.</u> DATE SIGNED <u>OCT 7, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR. M.D.</u>				WASHINGTON 17, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/10/58</u>		<u>Fort Lincoln Cem.</u>		<u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dallen's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 9 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert S. Travis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11612

Reg. Dist. No.

11678

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4950 Temple Hills Road S.E.		e. STREET ADDRESS 5260 St. Barnabas Road S.E.	
3. NAME OF DECEASED (Type or print) John Owen Brady Jr.		4. DATE OF DEATH Ocotber 17 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29/31 27 yrs.
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Owen Brady Sr.		14. MOTHER'S MAIDEN NAME Margaret Leone Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.11		16. SOCIAL SECURITY NO.	
17. INFORMANT John Owen Brady Sr., same as # 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Gun shot wound of the head Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in the right temple with a revolver	
20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 10/17/58		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Place of death Temple Hills P.G., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Ocotber 17, 1958	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-20-58	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) Oxon Hill (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR OCT 20 '58	
ADDRESS 1661- Good Hope Rd SE Wash. D.C. (20)		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11679

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Seat Pleasant Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seat Pleasant</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seat Pleasant</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5808 Rollins Ave.</i>		d. STREET ADDRESS <i>5808 Rollins Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>John William Brown</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/22/1866</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Oil merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Madison Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wm Brown</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Spencer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>John H.C. Brown</i> Address <i>5804 Rollins Ave. Seat Pleasant</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> (c) <i>Senile degeneration</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/27</i> , 19 <i>58</i> , to <i>10/27</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/27</i> , 19 <i>58</i> , and that death occurred at <i>6 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Duys</i>		ADDRESS (Street, city or town, state) <i>6124 Central Ave SE. Capitol Heights (Wash DC)</i>	
PHYSICIAN'S NAME (Type) <i>PETER DUYS</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10/29/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Church</i>	22d. LOCATION (City, town, or county) (State) <i>Oak Park Madison Co Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		ADDRESS <i>517 11th St SE</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11673 CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	

## 11631 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>1 Hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6707 Eades St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Jane</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>9</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Jan. 1869</b>		9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Fronia B. Dean, Norton, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Myocardial infarction - acute</b> DUE TO <b>Arteriosclerosis of heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis of heart</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abdominal ulcer &amp; hemorrhage</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <b>July 1956</b> , to <b>Oct 99</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 99</b> , 19 <b>58</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Max M. Herzberg</b>		ADDRESS (Street, city or town, state) <b>7016 - grey ST., Seat Pleasant, Md.</b>		DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Dr. Max. Herzberg, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/13/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Pr. Geo. Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

Page No. 1

<p>1. NAME OF DECEASED                  JAMES J. HENRY</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  45</p>		<p>4. DATE OF DEATH                  Jan 10, 1931</p>	
<p>5. PLACE OF DEATH                  Home</p>		<p>6. CITY                  Boston</p>	
<p>7. COUNTY                  Suffolk</p>		<p>8. STATE                  Massachusetts</p>	
<p>9. CAUSE OF DEATH                  Myocardial Infarction</p>			
<p>10. MEDICAL HISTORY                  None</p>			
<p>11. OCCUPATION                  None</p>			
<p>12. SIGNATURE OF PHYSICIAN                  J. J. Henry</p>			
<p>13. SIGNATURE OF REGISTRAR                  J. J. Henry</p>			
<p>14. SIGNATURE OF WITNESSES                  J. J. Henry</p>			
<p>15. SIGNATURE OF DECEASED                  J. J. Henry</p>			

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11615

Reg. Dist. No.

11632

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Dead on arrival X Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS / Box 193 Route # 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mark Dexter Chapman		4. DATE OF DEATH October 7 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1958
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Clifton S. Chapman		14. MOTHER'S MAIDEN NAME Geneva Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Geneva Chapman, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Toxemia DUE TO (b) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED October 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.10.58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 1820 9th St., N.W.	
24a. REC'D BY REGISTRAR OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

2063306XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA  
COUNTY OF

11

RECEIVED  
JAN 10 1900

10 AM  
JAN 10 1900

ALABAMA STATE DEPARTMENT OF HEALTH-BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-32

DEATH CERTIFICATE

ALABAMA

11-32

THIS IS TO CERTIFY THAT on the 10th day of January 1900, at the County of Jefferson, State of Alabama, died \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# CERTIFICATE OF DEATH

11616

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>16 West Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6603 Karlson Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer. M. Cole</b>		4. DATE OF DEATH Month <b>October. 26</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16. 1870</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Washington D.C.</b>	
13. FATHER'S NAME <b>Francis. Cole</b>		14. MOTHER'S MAIDEN NAME <b>Frances. Middleton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Frances E. Cole. Son</b>	
17. INFORMANT <b>Frances E. Cole. Son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension, chronic</b> DUE TO (c) <b>Arteriosclerosis generalized</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 Mar 1951</b> to <b>26 Oct 1958</b> , that I last saw the deceased alive on <b>26 Oct 1958</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5315-16th St. N.W. Wash D.C.</b> DATE SIGNED <b>26 Oct 58</b>			
ACTUAL SIGNATURE <b>Francis Coleman</b>		PHYSICIAN'S NAME (Type) <b>Lee. Funeral Home</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10.29.58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee. Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '58</b>	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15M 10/57



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11633 Items 13, 14 Film G236 11-20-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>		d. STREET ADDRESS <u>1419-58th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward David Collier</u>		4. DATE OF DEATH <u>Oct 1- 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-11</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Compression</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subdural hemorrhage</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blow or fall on head</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-55 9-30- 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Chapel Oaks Pr. Geo</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines &amp; Co.</u> ADDRESS <u>3015 12th St., NE</u>		24a. REC'D BY REGISTRAR <u>OCT 6 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, cause of death, and examiner details.]*

*[Faint handwritten text, possibly a signature or name, located in the lower right section of the form.]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11618

Reg. Dist. No.

11634

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Westmoreland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldhams 83X-9	
c. LENGTH OF STAY IN 1b D O A		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rufus Bailey Dameron		4. DATE OF DEATH October 5, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1880
9. AGE (In years birth day) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mail carrier	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph S Dameron		14. MOTHER'S MAIDEN NAME Amelia Ambrose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT John S Dameron		5004 26th Avenue Hillcrest Estates, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 x Acute Congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/58	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) Oldhams Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Gascha Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 8 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

2

99

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11604

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 5 mon.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>		d. STREET ADDRESS <b>5706--40th Ave.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5706--40th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>EDWARD</b> Last <b>DOEBLER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15th,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25th, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Carrier (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Post Office Dept. Hastings, Minn.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Otto Doebler</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Sommers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Helen Stover, 5706--40th Ave. Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebro-vascular arterio-sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1958</b> to <b>October 15, 1958</b> that I last saw the deceased alive on <b>October 14, 1958</b> and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. S. FLEISCHER, M.D.</b>		ADDRESS (Street, city or town, state) <b>5432 Queens Chapel Rd</b>	
PHYSICIAN'S NAME (Type) <b>R. S. FLEISCHER, M.D.</b>		DATE SIGNED <b>10/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16th, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cannon Falls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cannon Falls, Minn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		ADDRESS <b>4201 N. 1st St.</b>	
24a. REC'D BY REGISTRAR <b>Oct 17 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

12608

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1958		Baltimore		Natural	
TIME OF DEATH		AGE		SEX	
10:00 AM		65		Male	
RACE		EDUCATION		OCCUPATION	
White		High School		Retired	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 10 1893		Maryland		JAN 10 1915	
FATHER'S NAME		MOTHER'S NAME		PREVIOUS MARRIAGES	
John Doe		Jane Doe		None	
CAUSE OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE	
Heart Disease		Myocardial Infarction		Atherosclerosis	
SYMPTOMS		SIGNS		LABORATORY EXAMINATIONS	
Chest pain, shortness of breath		Diagnosis		X-ray, ECG	
TREATMENT		HISTORY		FAMILY HISTORY	
Medication, rest		Previous illnesses		Hypertension, Diabetes	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME	
JAN 12 1958		Baltimore		Doe Funeral Home	
DATE OF REGISTRATION		REGISTRATION OFFICE		REGISTRATION NUMBER	
JAN 15 1958		Baltimore		12608	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11605 CERTIFICATE OF DEATH

11620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt Rainier, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattsville Nursing Home</b>		d. STREET ADDRESS <b>3808 32th street,.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Love</b> Last <b>Dorr</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 27, 1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>Forrestville New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Shattuck</b>		14. MOTHER'S MAIDEN NAME <b>Dora Bennett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Philip C Dorr</b>		Address <b>Mt Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Debility &amp; Senility</b> DUE TO (c) <b>54 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy both Grand &amp; petit mal</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-19</b> , 19 <b>37</b> , to <b>10-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-29</b> , 19 <b>58</b> , and that death occurred at <b>3:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Waldo B. Moyers M.D. 3503 Perry St 10-3-58</b>			
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>		PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers Mt. Rainier, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 4, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>	
24a. REC'D BY REGISTRAR <b>Oct 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE DEPARTMENT OF HEALTH—SALT LAKE CITY 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11680 CERTIFICATE OF DEATH

11621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) Institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>Penna.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b> Jessup 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL, ANDREWS</b>		d. STREET ADDRESS <b>312 Hill Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>INFANT DUCHAK</b>		4. DATE OF DEATH Month Day Year <b>OCT 27 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 27 '58</b>
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>— — 2 30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BARRY JOHN DUCHAK</b>		14. MOTHER'S MAIDEN NAME <b>GORGETTE ANN SWITZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NA</b> (If yes, give war or dates of service) <b>NA</b>		16. SOCIAL SECURITY NO. <b>NA</b>	
17. INFORMANT <b>FATHER. SEE # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrauterine anoxia</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1645-1915</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1645 to 1915</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1905</b> , 19 <b>58</b> , and that death occurred at <b>1915</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2700T38</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Douglas E. Perce</b> M.D. <b>USAF HOSPITAL, ANDREWS</b>			
PHYSICIAN'S NAME (Type) <b>DOUGLAS E. PERCE CAPT. USAF(CMC) ANDREWS AFB, WASH 25 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>10/29/58</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>Jessup Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Jr</b> ADDRESS <b>517 11th St SE</b>		24a. REC'D BY REGISTRAR <b>OCT 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

2050191XV2



11635

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edwards</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/06</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9. AGE (In years lost birthday) <u>51</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Isaac Edwards</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>bleachitis Mellitus</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 19____, to <u>October 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 28</u> , 19 <u>58</u> , and that death occurred at <u>5:10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6114 Central Ave</u> DATE SIGNED <u>11/29/58</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Hgt Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-1-1958</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>CARVER Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>MURKIRK Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 Nat. Trw.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>
		DATE <u>NOV 3 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOYD

February 22, 1952

At Baltimore, Maryland, on February 22, 1952, at the residence of the decedent, WILLIAM BOYD, aged 72 years, died of natural causes.

## 11600 CERTIFICATE OF DEATH

11623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>4905 Fox St,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EVA</b> First <b>JEANETTE</b> Middle <b>ENGLISH</b> Last		4. DATE OF DEATH <b>OCT</b> Month <b>1st</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 23-1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>23</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>William G. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Frances Olivia Stone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs Avis B. Rowland.</b> Address <b>4905 Fox St College Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Liver</b> <b>156.1</b> DUE TO (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 9 - 1937</b> , to <b>Oct 1 - 1958</b> , that I last saw the deceased alive on <b>Oct 1 - 1958</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>7 - Brooks Avenue Gaithersburg, Md.</b>	
DATE SIGNED <b>7-1-58</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM C. MILLER</b>		<b>Gaithersburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b> ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '58</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11800 CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William F. Miller</i>		2. SEX <i>Male</i>		3. AGE <i>70</i>	
4. DATE OF BIRTH <i>Dec 1 - 1887</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF DEATH <i>Dec 1 - 1957</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>W. C. Miner</i>	
13. SIGNATURE OF REGISTRAR <i>W. C. Miner</i>		14. SIGNATURE OF WITNESS <i>W. C. Miner</i>		15. SIGNATURE OF WITNESS <i>W. C. Miner</i>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11624

11636

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 Hours</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>		d. STREET ADDRESS <b>1308 Hamilton St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Agnes L. Espey</b>		4. DATE OF DEATH Month Day Year <b>October 3 19 58</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-13-85</b>		9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Justice of the Peace</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Francis H Espey</b>		14. MOTHER'S MAIDEN NAME <b>Mina G. Mitchell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mina Espey Carroll</b>		Address <b>Hyattsville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>260X Diabetic Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I attended the deceased from <b>2-5</b> , 19 <b>40</b> , to <b>10-3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-3</b> , 19 <b>58</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Hyattsville Md.</b>		DATE SIGNED <b>Oct 10-3-58</b>		ACTUAL SIGNATURE <b>A. Deitz</b>		M.D. <b>Hyattsville Md.</b>		PHYSICIAN'S NAME (Type) <b>Dr. Aaron Deitz</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 7, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11637

## CERTIFICATE OF DEATH

11625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>7 hrs. 36 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b> X d. STREET ADDRESS <b>915 65th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Ford</b>			4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>19 58</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-58</b>	9. AGE (In years last birthday) yrs. <b>7</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>36</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newborn</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Charles</b>			14. MOTHER'S MAIDEN NAME <b>Palestine Nichols</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <b>10-13, 1958</b> , to <b>10-13, 1958</b> , that I last saw the deceased alive on <b>10-13, 1958</b> , and that death occurred at <b>11:00AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>					
DATE SIGNED <b>10/13/58</b>							
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>10/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>			
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR <b>Harry W. Penn, Jr.</b> Administrator.		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

\_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11638

## CERTIFICATE OF DEATH

11626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>1 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henrietta Forest</u>				4. DATE OF DEATH <u>October 27 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife in own home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John Messenger</u>			
14. MOTHER'S MAIDEN NAME <u>White</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Bladen J. Forrest</u> Address <u>Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 12 1958</u> , to <u>Oct. 27 1958</u> , that I last saw the deceased alive on <u>Oct. 27 1958</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles C. Hageage</u>				ADDRESS (Street, city or town, state) <u>3308 Perry St., Mt. Rainier, Md.</u>			
DATE SIGNED <u>10/28/58</u>							
PHYSICIAN'S NAME (Type) <u>CHARLES C. HAGEAGE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/31/58</u>		<u>Holy Rood</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11627

11606

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2025 Rittenhouse Street</b>			d. STREET ADDRESS <b>2025 Rittenhouse Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elmont Prentis Forman</b>			4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-14</b>		9. AGE (In years last birthday) <b>44</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transfer Company</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Edward Forman</b>			14. MOTHER'S MAIDEN NAME <b>Letitia Snyder</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 2.</b>		16. SOCIAL SECURITY NO. <b>280-18-8084</b>	17. INFORMANT <b>Helen L. Forman; same address as # 2.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gunshot wound of head</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Self inflicted pistol wound of head.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>10- 23- 58</b> p. m. <b>4.00</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hyattsville Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 23, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 27, 1958</b>	22c. NAME OF CEMETERY OR CREMATION <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the FUNERAL DIRECTOR; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808

22. *Not a poet*

15-05-0

五、注意

• 20-19-1981 Hefner, Torrey; same address as 1. 2.

Wentville 11 Dec 1954

\_\_\_\_\_

## 11639 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>General Del.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>??</b>	9. AGE (In years last birthday) yrs. <b>75</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>??</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Balt. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>?? Unknown</b>				14. MOTHER'S MAIDEN NAME <b>??</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>??</b>		16. SOCIAL SECURITY NO. <b>??</b>		17. INFORMANT <b>Mary Wallace-Upper Marlboro Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma Stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left subdiaphragmatic abscess.</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>12:05 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Harold B. Tidler</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Harold Tidler, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 15, '58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Drexel H.A. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E. Berry Huntingtown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>OCT 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11629

11640

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Lanham--Severn Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pearl Gertrude Green</b>				4. DATE OF DEATH Month Day Year <b>October 28 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1906</b>		9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George F. McKay</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Clements</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Chester T. Green; 5103 Paducah Road, College Park.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral compression</b> 331/x DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Intracranial hemorrhage</b> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 28, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10.30.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Lee Funeral Home/ 300. 4th. st .N.E.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-20

Since 1901

In 1901

Since 1901

October 21

Green

1901

U. S. 1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11641

CERTIFICATE OF DEATH

11630

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Greenwell</b>				4. DATE OF DEATH <b>October 9 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 8, 1958</b>	
9. AGE (In years last birthday) <b>1</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Joseph P. Greenwell</b>				14. MOTHER'S MAIDEN NAME <b>Helen Marie Buck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Helen Greenwell</b>				Address <b>Mother Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atelectasis</b> <b>7625</b> DUE TO <b>Pneumatury</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 8, 1958</b> , to <b>October 9, 1958</b> , that I last saw the deceased alive on <b>October 9, 1958</b> , and that death occurred at <b>8:22 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>				ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>				DATE SIGNED <b>10/12/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>10/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr. Administrator.</b>				24a. REC'D BY REGISTRAR <b>OCT 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____ _____ _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____ _____ _____		DATE OF BIRTH _____ _____ _____	
PLACE OF BIRTH _____ _____ _____		OCCUPATION _____ _____ _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF DEATH _____ _____ _____	
TIME OF DEATH _____ _____ _____		PLACE OF DEATH _____ _____ _____	
CAUSE OF DEATH _____ _____ _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	
SIGNATURE OF PHYSICIAN _____ _____ _____		SIGNATURE OF REGISTRAR _____ _____ _____	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11631

11620

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7805 Lockney Avenue</b>			d. STREET ADDRESS <b>7805 Lockney Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Carl Wilhelm Grosskurth</b>			4. DATE OF DEATH Month <b>October</b> Day <b>3</b> , Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24, 1891</b>		9. AGE (In years last birthday) <b>67</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Wilhelm Grosskurth</b>			14. MOTHER'S MAIDEN NAME <b>Emma Augusta Brand</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W.1</b>		16. SOCIAL SECURITY NO. <b>217-12-5943</b>	17. INFORMANT <b>Edward Grosskurth;</b> Address <b>8609 Quebec Street Berwyn Heights</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>  442X DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b>  DUE TO (c) _____ </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DATE SIGNED <b>October 3, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b> ADDRESS <b>Silver Spring, Md.</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997

Florida

98 2002 43 31 000000

2. *Chlorophyll*

-2-15

United States of America

DATE: 12/10/2019

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11642

## CERTIFICATE OF DEATH

11632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN 1b <b>adm. 9-23-58</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 1556.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>LAUREL SANITARIUM</b>			d. STREET ADDRESS <b>708 BULKINGHAM DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>GRUESS</b> Last <b>GRUESS</b>			4. DATE OF DEATH Month <b>10</b> - Day <b>15</b> - Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-1884</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COMPANION-RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FRANCE</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOSEF MITH</b>			14. MOTHER'S MAIDEN NAME <b>EMILIA GROSS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>HOSPITAL RECORDS LAUREL SANITARIUM</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy 334</b> DUE TO <b>cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>334X</b> (c) <b>306</b>					INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>many months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis 306</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>9-23-58</b> to <b>10-15-58</b> , that I last saw the deceased alive on <b>10-15-58</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>ERIK A. P. KRAEMER</b>		M.D. <b>LAUREL SANITARIUM</b>		DATE SIGNED <b>9-15-58</b>	
PHYSICIAN'S NAME (Type) <b>ERIK A. P. KRAEMER</b>		<b>LAUREL MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Linden Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. D. Langansky &amp; Son - Wash. D.C.</b>		ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 16 '58</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JAMES		2. SEX Male		3. AGE 35	
4. DATE OF DEATH 1912		5. TIME OF DEATH 10:30		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Myocardial Infarction		9. PERIOD OF ILLNESS 2 weeks	
10. SIGNATURE OF PHYSICIAN J. J. James		11. SIGNATURE OF WITNESSES J. J. James		12. SIGNATURE OF DECEASED J. J. James	
13. SIGNATURE OF REGISTRAR J. J. James		14. SIGNATURE OF CLERK J. J. James		15. SIGNATURE OF JURY J. J. James	
16. SIGNATURE OF JURY J. J. James		17. SIGNATURE OF JURY J. J. James		18. SIGNATURE OF JURY J. J. James	
19. SIGNATURE OF JURY J. J. James		20. SIGNATURE OF JURY J. J. James		21. SIGNATURE OF JURY J. J. James	
22. SIGNATURE OF JURY J. J. James		23. SIGNATURE OF JURY J. J. James		24. SIGNATURE OF JURY J. J. James	
25. SIGNATURE OF JURY J. J. James		26. SIGNATURE OF JURY J. J. James		27. SIGNATURE OF JURY J. J. James	
28. SIGNATURE OF JURY J. J. James		29. SIGNATURE OF JURY J. J. James		30. SIGNATURE OF JURY J. J. James	
31. SIGNATURE OF JURY J. J. James		32. SIGNATURE OF JURY J. J. James		33. SIGNATURE OF JURY J. J. James	
34. SIGNATURE OF JURY J. J. James		35. SIGNATURE OF JURY J. J. James		36. SIGNATURE OF JURY J. J. James	
37. SIGNATURE OF JURY J. J. James		38. SIGNATURE OF JURY J. J. James		39. SIGNATURE OF JURY J. J. James	
40. SIGNATURE OF JURY J. J. James		41. SIGNATURE OF JURY J. J. James		42. SIGNATURE OF JURY J. J. James	
43. SIGNATURE OF JURY J. J. James		44. SIGNATURE OF JURY J. J. James		45. SIGNATURE OF JURY J. J. James	
46. SIGNATURE OF JURY J. J. James		47. SIGNATURE OF JURY J. J. James		48. SIGNATURE OF JURY J. J. James	
49. SIGNATURE OF JURY J. J. James		50. SIGNATURE OF JURY J. J. James		51. SIGNATURE OF JURY J. J. James	
52. SIGNATURE OF JURY J. J. James		53. SIGNATURE OF JURY J. J. James		54. SIGNATURE OF JURY J. J. James	
55. SIGNATURE OF JURY J. J. James		56. SIGNATURE OF JURY J. J. James		57. SIGNATURE OF JURY J. J. James	
58. SIGNATURE OF JURY J. J. James		59. SIGNATURE OF JURY J. J. James		60. SIGNATURE OF JURY J. J. James	
61. SIGNATURE OF JURY J. J. James		62. SIGNATURE OF JURY J. J. James		63. SIGNATURE OF JURY J. J. James	
64. SIGNATURE OF JURY J. J. James		65. SIGNATURE OF JURY J. J. James		66. SIGNATURE OF JURY J. J. James	
67. SIGNATURE OF JURY J. J. James		68. SIGNATURE OF JURY J. J. James		69. SIGNATURE OF JURY J. J. James	
70. SIGNATURE OF JURY J. J. James		71. SIGNATURE OF JURY J. J. James		72. SIGNATURE OF JURY J. J. James	
73. SIGNATURE OF JURY J. J. James		74. SIGNATURE OF JURY J. J. James		75. SIGNATURE OF JURY J. J. James	
76. SIGNATURE OF JURY J. J. James		77. SIGNATURE OF JURY J. J. James		78. SIGNATURE OF JURY J. J. James	
79. SIGNATURE OF JURY J. J. James		80. SIGNATURE OF JURY J. J. James		81. SIGNATURE OF JURY J. J. James	
82. SIGNATURE OF JURY J. J. James		83. SIGNATURE OF JURY J. J. James		84. SIGNATURE OF JURY J. J. James	
85. SIGNATURE OF JURY J. J. James		86. SIGNATURE OF JURY J. J. James		87. SIGNATURE OF JURY J. J. James	
88. SIGNATURE OF JURY J. J. James		89. SIGNATURE OF JURY J. J. James		90. SIGNATURE OF JURY J. J. James	
91. SIGNATURE OF JURY J. J. James		92. SIGNATURE OF JURY J. J. James		93. SIGNATURE OF JURY J. J. James	
94. SIGNATURE OF JURY J. J. James		95. SIGNATURE OF JURY J. J. James		96. SIGNATURE OF JURY J. J. James	
97. SIGNATURE OF JURY J. J. James		98. SIGNATURE OF JURY J. J. James		99. SIGNATURE OF JURY J. J. James	
100. SIGNATURE OF JURY J. J. James		101. SIGNATURE OF JURY J. J. James		102. SIGNATURE OF JURY J. J. James	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11643

## CERTIFICATE OF DEATH

12830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 hr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Habas</b>		4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Oct. 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. FATHER'S NAME <b>Franklin D. Habas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lou Lusby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>14 HR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>17 OCT. 1958</b> , to <b>18 OCT. 1958</b> , that I last saw the deceased alive on <b>17 OCT. 1958</b> , and that death occurred at <b>1:40AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>402 MAIN ST. LAUREL MD 10915</b> DATE SIGNED _____			
ACTUAL SIGNATURE <b>Dr. John R. Buell, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Dr. John R. Buell, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>11/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

20772/1XVO

創 刊 号 第 一 卷 第 一 期

11681

## CERTIFICATE OF DEATH

11633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Laurel</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel R.F.D.#2</u>				c. LENGTH OF STAY IN 1b <u>12 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel R.F.D.#2</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Frank</u> Last <u>Hance</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 26 1917</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Bowie Md. U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jesse Hance</u>				14. MOTHER'S MAIDEN NAME <u>Mary Feasy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>263-36-5950</u>		17. INFORMANT Address <u>Stella Hance Laurel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma of the</u> DUE TO (c) <u>Prostate</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>9-21</u> , 19 <u>58</u> , to <u>10-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-3</u> , 19 <u>58</u> , and that death occurred at <u>8:25 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Golda Pierandrei</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Oct 6-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Northwood</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hance</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*Journal of Management Education*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11682

CERTIFICATE OF DEATH

Reg. Dist. No. 11634

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. LENGTH OF STAY IN 1b <b>4 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT 3 Bx 591</b>				d. STREET ADDRESS <b>RT 3 Bx 591</b>			
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>MAY</b> Last <b>HATCHER</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>1</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 7, 1885</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING IND.</b>		11. BIRTHPLACE (State or foreign country) <b>CULPEPPER, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES LEGG</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N</b>		16. SOCIAL SECURITY NO. <b>579-30-6360</b>		17. INFORMANT <b>DORA M. BURNS - DAUGHTER -</b> Address <b>RT 3 Bx 591 CLINTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (WITH MYOCARDIAL INFARCTION)</b> DUE TO (c) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1/2 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>NONE</b> p.m. <b>1</b>		20d. INJURY OCCURRED While at work <b>NONE</b> Not while at work <b>NONE</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State) <b>NONE</b>	
21. I certify that I attended the deceased from <b>Jan. 1956</b> to <b>Present</b> , that I last saw the deceased alive on <b>Sept. 29, 1958</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Branch Ave. Clinton, Md.</b> DATE SIGNED <b>10/1/58</b> ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. BRANCH AVE. CLINTON, MD. 10/1/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct 3 - 58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros 1661 1st St NE</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11983

11984

NAME OF DECEASED		CLAYTON, J. A.	
AGE		45	
SEX		M	
DATE OF DEATH		MAY 10 1918	
PLACE OF DEATH		HOMER, MASS.	
CAUSE OF DEATH		TUBERCULOSIS OF LUNGS	
DISEASE OR INJURY		TUBERCULOSIS OF LUNGS	
PERIOD OF ILLNESS		SEVERAL MONTHS	
PLACE OF BIRTH		MASS.	
DATE OF BIRTH		MAY 10 1873	
FATHER'S NAME		J. A. CLAYTON	
MOTHER'S NAME		M. A. CLAYTON	
OCCUPATION		FARMER	
EDUCATION		HIGH SCHOOL	
MARRIED		YES	
SINGLE		NO	
WIDOWED		NO	
DIVORCED		NO	
MILITARY SERVICE		NO	
REMARKS		TUBERCULOSIS OF LUNGS	
SIGNATURE OF PHYSICIAN		J. A. CLAYTON	
SIGNATURE OF MINISTER		J. A. CLAYTON	
SIGNATURE OF CORONER		J. A. CLAYTON	
SIGNATURE OF DEPUTY CLERK		J. A. CLAYTON	
SIGNATURE OF TOWN CLERK		J. A. CLAYTON	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11635

11683

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Forestville</u>	
c. LENGTH OF STAY in lb <u>3 month</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3330 Roslyn Ave</u>		d. STREET ADDRESS <u>3330 Roslyn Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur Clarence Heller</u>		4. DATE OF DEATH <u>Oct 21 1958</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 6, 1888</u>	
9. AGE (in years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Heller</u>		14. MOTHER'S MAIDEN NAME <u>Lydia McDonald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>328-01-0789</u>	
17. INFORMANT <u>William C Schmidt, names as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 21, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Southland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>OCT 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11644

## CERTIFICATE OF DEATH

11636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale Md</b>		c. LENGTH OF STAY IN 1b <b>26 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6111 44th ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Pickett</b> Last <b>Helm</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>19 58-</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1883</b>
9. AGE (In years and birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Free lance writer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Pickett Helm</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Harwood Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Selma W Helm</b>		Address <b>Riverdale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 1956</b> to <b>OCT 30, 1958</b> , that I last saw the deceased alive on <b>OCT 22, 1958</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman Donat Comeau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Pennys ST</b> DATE SIGNED <b>10/30/58</b>	
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEAU</b>		<b>MT RAINIER MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 1, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11000

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
TOMAS, JAMES		M		65		JAN 15 1855		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		2 WEEKS		HOME	
DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
JAN 20 1900		10:00 AM		100.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
J. B. SMITH		A. B. JONES		TOMAS, JAMES		J. B. SMITH		J. B. SMITH	
DATE OF ENTRY		HOUR OF ENTRY		TEMPERATURE		PULSE		RESPIRATIONS	
JAN 20 1900		10:00 AM		100.0		90		20	

1

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11637  
Reg. Dist. No.

11684

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b>			c. LENGTH OF STAY IN 1b <b>Landover</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1107 54th Avenue</b>			e. STREET ADDRESS <b>Box 61, Hill Road</b>		
3. NAME OF DECEASED (Type or print) <b>Clarence Edward Henson</b>			4. DATE OF DEATH Month <b>October</b> Day <b>7th</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October, 1991</b>		9. AGE (In years last birthday) <b>66</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Katherine Jackson</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Frank Henson, 998 County Road, District Heights</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Bladensburg</b>	(County) <b>N.E.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 7, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-10-58</b>	22b. DATE THEREOF <b>10-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Bladensburg</b>	(State) <b>N.E.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington &amp; Son - 467-N St. NW</b>		ADDRESS <b>467-N St. NW</b>		24a. REC'D BY REGISTRAR <b>Oct 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11645

## CERTIFICATE OF DEATH

Reg. Dist. No.

11638

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Georges</b> c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1630 Upshur St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruth</b> First <b>E.</b> Middle <b>Hilley</b>		4. DATE OF DEATH <b>Oct.</b> Month <b>26</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25, 1894</b>
9. AGE (In years birthdate) <b>64</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>Archibald Franklin Fairfax</b>		14. MOTHER'S MAIDEN NAME <b>Lu Emma Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carl N. Hilley</b>		Address <b>1630 Upshur St. N. W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>463 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phlebotrombosis LEFT Leg</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease with CONDUCTION INSUFFICIENCY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>4 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/24</b> , 19 <b>58</b> , to <b>10/26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/26</b> , 19 <b>58</b> , and that death occurred at <b>1:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman D. Coneau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St. Prince Georges Co. Md.</b>	
PHYSICIAN'S NAME (Type) <b>Norman D. Coneau</b>		DATE SIGNED <b>10/26/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>10/30/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>OCT 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>William L. K...</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BASTION 10-15-1918  
11635 CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar	
JAMES H. BROWN		Male		35		1918		1918		Baltimore, Md.		Typhoid fever		J. H. BROWN		J. H. BROWN	
10. Name of informant		11. Relationship		12. Occupation		13. Education		14. Religion		15. Marital status		16. Date of marriage		17. Date of divorce		18. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
19. Name of informant		20. Relationship		21. Occupation		22. Education		23. Religion		24. Marital status		25. Date of marriage		26. Date of divorce		27. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
28. Name of informant		29. Relationship		30. Occupation		31. Education		32. Religion		33. Marital status		34. Date of marriage		35. Date of divorce		36. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
37. Name of informant		38. Relationship		39. Occupation		40. Education		41. Religion		42. Marital status		43. Date of marriage		44. Date of divorce		45. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
46. Name of informant		47. Relationship		48. Occupation		49. Education		50. Religion		51. Marital status		52. Date of marriage		53. Date of divorce		54. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
55. Name of informant		56. Relationship		57. Occupation		58. Education		59. Religion		60. Marital status		61. Date of marriage		62. Date of divorce		63. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
64. Name of informant		65. Relationship		66. Occupation		67. Education		68. Religion		69. Marital status		70. Date of marriage		71. Date of divorce		72. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
73. Name of informant		74. Relationship		75. Occupation		76. Education		77. Religion		78. Marital status		79. Date of marriage		80. Date of divorce		81. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
82. Name of informant		83. Relationship		84. Occupation		85. Education		86. Religion		87. Marital status		88. Date of marriage		89. Date of divorce		90. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
91. Name of informant		92. Relationship		93. Occupation		94. Education		95. Religion		96. Marital status		97. Date of marriage		98. Date of divorce		99. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							
100. Name of informant		101. Relationship		102. Occupation		103. Education		104. Religion		105. Marital status		106. Date of marriage		107. Date of divorce		108. Date of remarriage	
J. H. BROWN		Son		Clerk		High School		Roman Catholic		Single							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11646

CERTIFICATE OF DEATH

11639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b> d. STREET ADDRESS <b>1108 54 Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Janifer</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 6, 1958</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>9</b> Hours <b>9</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Philip Sylvester Janifer</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>La Verne</b>		Address <b>Gertrude Brown</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (variable 1 lb 6 oz)</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Abnormal pulmonary ventilation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 6, 1958</b> , to <b>October 8, 1958</b> , that I last saw the deceased alive on <b>October 8, 1958</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Christensen</b>		ADDRESS (Street, city or town, state) <b>College Park, Md</b> DATE SIGNED <b>10/8/58</b>	
PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>10/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince L George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>OCT 16 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 ~~8~~  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 8 & 9, Film G-235 10/29/58, cag

11647 CERTIFICATE OF DEATH

11640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount</b> d. STREET ADDRESS <b>1018 - 59th - Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H.</b> Last <b>Jenkins</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15 - 1888</b> 9. AGE (In years last birthday) <b>69</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Susie Jenkins 1018 59th Avenue</b>	
17. INFORMANT <b>Susie Jenkins</b>		Address <b>1018 59th Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Acute cerebral vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic</b> DUE TO <b>Stroke</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6124 Central Ave</b> DATE SIGNED <b>10/17/58</b>			
ACTUAL SIGNATURE <b>William Brainin</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. William Brainin</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-20-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhine &amp; Co.</b>		ADDRESS <b>3015 - 12th St. N.E.</b>	
24a. REC'D BY REGISTRAR <b>22 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

1 1 1

11607

## CERTIFICATE OF DEATH

11641

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>47X3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				e. STREET ADDRESS <b>1347 Quincy St., N.W.</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Oliver E. Keenan</b>				4. DATE OF DEATH <b>10-7-1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-76</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>		11. BIRTHPLACE (State or foreign country) <b>VERMONT</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>PETER J. KEENAN</b>			
14. MOTHER'S MAIDEN NAME <b>MARY H. CASEY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>334X</b>				17. INFORMANT <b>Agnes E. Murphy</b> Address <b>4712 Butterworth Pk. N.W. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular disease</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General arteriosclerosis</b> DUE TO (c) <b>1 year +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 year</b> <b>1 year +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>July 1955</b> to <b>OCT 7, 1958</b> , that I last saw the deceased alive on <b>OCT. 7, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. Monahan M.D.</b>				ADDRESS (Street, city or town, state) <b>3000 Conn Ave. Oct. 7-1958</b>			
PHYSICIAN'S NAME (Type) <b>Thomas F. Monahan</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery Washington, D.C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Collins</b> ADDRESS <b>3821-14th St. N.W. Wash. D.C.</b>				24a. RECEIVED BY REGISTRAR DATE <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1900-01-01		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Maryland		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Age at Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
50 years		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Date of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
1950-10-15		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Time of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10:00 AM		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Signature of Physician		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. B. Smith		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	
Signature of Registrar		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
A. C. Jones		1950-10-15		Male		White		Married		Farmer		Heart Disease		Home		1950-10-15		10:00 AM		J. B. Smith		A. C. Jones	

11621

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK, MD.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 TAKOMA PARK, MARYLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>815 LARCH AVENUE, TAKOMA PARK, MARYLAND</b>				d. STREET ADDRESS <b>815 LARCH AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>KIRIAZOGLOU</b> Last				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 12, 1891</b>	9. AGE (In years lost birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b></b> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME-MAKER</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NICK</b>				14. MOTHER'S MAIDEN NAME <b>IRENE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>AVENUE TAKOMA PARK</b> <b>MRS. MICHAEL GRAMATIKOS (DAUGHTER) 815-LARCH</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>1 year</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Aug 1, 1957</b> , to <b>Oct 16, 1958</b> , that I last saw the deceased alive on <b>Oct 12, 1958</b> , and that death occurred at <b>1:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James J. Foster</b> M.D.				ADDRESS (Street, city or town, state) <b>1746 K St N.W.</b> DATE SIGNED <b>WASH D.C.</b>			
PHYSICIAN'S NAME (Type) <b>JAMES J. FOSTER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/18/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARTIN W. HYSOING COMPANY 1300 N. ST., N.W. - WASH. D.C.</b>				24a. REC'D BY REGISTRAR <b>OCT 17 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Anthony Frank</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

11622

Items 1, 2, 4 Film 6235 10-27-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 11643

1. PLACE OF DEATH a. COUNTY <i>Prince Georges Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
c. LENGTH OF STAY IN 1b <i>3 years</i>		d. STREET ADDRESS <i>17312 Slowly Avenue</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1312 Flower Ave. (At home)</i>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <i>Mary Mc Elwee Klein</i>		4. DATE OF DEATH <i>October 19 19 58</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-9-1887</i>
9. AGE (In years last birthday) <i>70 yrs.</i>		IF UNDER 1 YEAR: Months <i>11</i> Days <i>16</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Mc Elwee</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Mock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>M. Carl O Klein</i>		Address <i>7312 Flower Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Bronchial Pneumonia</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X none other</i>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>no accident or injury</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour a. m. <i></i> p. m. <i></i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Summer, 1928</i> , to <i>October 19, 1958</i> , that I last saw the deceased alive on <i>October 18, 1958</i> , and that death occurred at <i>1:48 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank L. Williman</i>		M.D. <i>2731 Connecticut Ave.</i>	
PHYSICIAN'S NAME (Type) <i>Frank L. Williman</i>		<i>Washington (8) DC</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-21-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>LEE FUNERAL HOME- DR</i>		ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
DATE <i>OCT 21 '58</i>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [Faint handwritten text]		2. SEX [Faint handwritten text]	
3. AGE [Faint handwritten text]		4. RACE [Faint handwritten text]	
5. DATE OF DEATH [Faint handwritten text]		6. PLACE OF DEATH [Faint handwritten text]	
7. TIME OF DEATH [Faint handwritten text]		8. CAUSE OF DEATH [Faint handwritten text]	
9. MANNER OF DEATH [Faint handwritten text]		10. SIGNATURE OF DECEASED [Faint handwritten text]	
11. SIGNATURE OF WITNESS [Faint handwritten text]		12. SIGNATURE OF PHYSICIAN [Faint handwritten text]	
13. SIGNATURE OF CLERK [Faint handwritten text]		14. SIGNATURE OF REGISTRAR [Faint handwritten text]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
 1950

## 11648 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>7 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Landover</b> d. STREET ADDRESS <b>2414 Columbia Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E</b> Last <b>Ladd</b>		4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29-1869</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unk.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Holly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia, Anemia</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ca of prostate metastases.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/6</b> , 19 <b>58</b> , to <b>10/13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>2:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis B. Bachrach</b>		ADDRESS (Street, city or town, state) <b>915 - 19 St. N.W. Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>F. Gasch's Sons</b>		DATE SIGNED <b>9/15-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grace Church</b>	22d. LOCATION (City, town, or county) (State) <b>Albemarle Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REG. D. BY REGISTRAR <b>Hyattsville, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>		DATE <b>Oct 20 1958</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILKINS  
BOLAND

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
WILKINS, BOLAND		Male		45		1910		1955		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Occupation		14. Education		15. Marital status		16. Usual residence		17. Usual place of work		18. Name of attending physician		19. Name of hospital		20. Name of funeral home		21. Name of cemetery		22. Name of burial place		23. Name of interment place		24. Name of crematorium	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

WILKINS  
BOLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11649 CERTIFICATE OF DEATH

11645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6117 - Shady Side Ave.		d. STREET ADDRESS 6117 Shadydide Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last LAUGHTON		4. DATE OF DEATH Month OCTOBER Day 29th. Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis P. Dunleavy		14. MOTHER'S MAIDEN NAME Annie Wachsmuth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		17. INFORMANT Mr Lyman J. Laughton-3rd- Son-Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary Occlusion (b) Anteriosclerotic Heart Disease (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH above	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 48 to 10-29-19 58, that I last saw the deceased alive on 10-28-19 58, and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Oliver		ADDRESS (Street, city or town, state) 6124 Central Ave. DATE SIGNED	
PHYSICIAN'S NAME (Type) Capital Heights Md.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Nov. 1, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE LEE FUNERAL HOME - WASHINGTON, D.C.		24a. REC'D BY REGISTRAR DATE NOV 3 '58	
		24b. REGISTRAR'S SIGNATURE Anthony J. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

## CERTIFICATE OF DEATH

For use in

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF PATHOLOGIST

NAME OF BACTERIOLOGIST

NAME OF RADIOLOGIST

NAME OF CLINICAL PATHOLOGIST

NAME OF LABORATORY

NAME OF HOSPITAL

NAME OF CITY

NAME OF STATE

NAME OF COUNTRY

NAME OF DEPARTMENT

NAME OF DIVISION

NAME OF SECTION

NAME OF OFFICE

11685

## CERTIFICATE OF DEATH

11646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DIST. OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENN DALE</b>		c. LENGTH OF STAY IN 1b <b>3 YRS 10 MOS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENN DALE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES R. LONG</b>		4. DATE OF DEATH <b>10 / 11 19 58</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/4/17</b>	
9. AGE (In years last birthday) <b>40</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		12. KIND OF BUSINESS OR INDUSTRY <b>BUS. MACHINES</b>	
13. BIRTHPLACE (State or foreign country) <b>WASH., D.C.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. FATHER'S NAME <b>CHARLES LONG</b>		16. MOTHER'S MAIDEN NAME <b>ROSALIE SMITH</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO. <b>578-10-1115</b>	
19. INFORMANT <b>DECEASED</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SPONTANEOUS PNEUMOTHORAX, RT.</b> DUE TO (b) <b>BULLOUS EMPHYSEMA RT. LUNG</b> DUE TO (c) <b>1 1/2 HRS. 3 YRS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>RTX</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULM. TUBERCULOSIS, LEFT UPPER LOBECTOMY, 10 Y &amp; LEFT THORACIC PLASTY 3/16</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/2 1955</b> to <b>10/11 1958</b> , that I last saw the deceased alive on <b>10/11 1958</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>GLENN DALE HOSP.</b> DATE SIGNED <b>10/12/58</b> ACTUAL SIGNATURE <b>MOE WEISS</b> M.D. <b>GLENN DALE, M.D.</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>10/15/58</b>		22b. NAME OF CEMETERY OR CREMATORY <b>ARL. NATL CEM-T.</b>	
22c. LOCATION (City, town, or county) <b>ARLINGTON, VA.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E. Duven</b>		24a. REC'D BY REGISTRAR <b>517 11th St DC</b>	
24b. REGISTRAR'S SIGNATURE <b>Oct 14 '58</b>		24c. REGISTRAR'S SIGNATURE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 10/57

CERTIFICATE OF DEATH

12882

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11686

CERTIFICATE OF DEATH

11647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights Dr.</u>		c. LENGTH OF STAY IN lb <u>19 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights</u>		d. STREET ADDRESS <u>17003 College Heights Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7003 College Heights Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Henry</u> Last <u>Zuehman</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1901</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>19</u> Hours <u>58</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>Edward F. W. Zuehman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Hasenbalg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>011-01-8776</u>		17. INFORMANT <u>David Charles Zuehman</u> Address <u>7003 College Heights Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>acute liver failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cirrhosis of liver</u> (c) <u>chronic severe alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 yrs</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-10</u> , 19 <u>55</u> to <u>9-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>58</u> , and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rowland F. Wilkinson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4404 Greensburg Road</u> <u>Rivindale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Rowland F. Wilkinson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Pr. Geo. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11017

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

11026

Reg. Dist. No.

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESS

11026

11026

11026

DATE OF DEATH

11026

11026

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11648

Reg. Dist. No.

11687

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>148 13th Street</b>		e. STREET ADDRESS <b>6th and Maple Avenue</b>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"><span>First <b>Gloria</b></span><span>Middle <b>Elizabeth</b></span><span>Last <b>Lyles</b></span></div>		4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-56</b>
9. AGE (In years last birthday) <b>2 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence Sylvester Lyle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Daniel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Address</b> <b>Mary Elizabet Daniels: same address.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Inhalation of smoke.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Suffocated in room due to conflagration in home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9.45</b> a. m. <b>10-25-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>house</b>		20f. (City or town) (County) (State) <b>Bowie Pr. Geo. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 25, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>10/30/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John F. McKinney, Jr.		Male		35	
Date of Death		Place of Death		Cause of Death	
October 22, 1966		Home		Myocardial Infarction	
Time of Death		Manner of Death		Occupation	
10:15 AM		Natural		Engineer	
Residence		Usual Residence		Place of Birth	
123 Main St., Boston, Mass.		123 Main St., Boston, Mass.		Boston, Mass.	
Physician		Medical Examiner		Hospital	
Dr. J. A. Smith		Dr. J. A. Smith		None	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
October 23, 1966		Boston, Mass.		[Seal]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11618 Item 1 Film G234 10-17-58 et

### CERTIFICATE OF DEATH

11649

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3267 Queenstown Dr., Apt. 303</u>		d. STREET ADDRESS <u>13267 Queenstown Dr. 303</u>	

<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Edward Lynch</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG 22 1882</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wash. Gas Light Co</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--------------------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------	-----------------------------------------------

13. FATHER'S NAME <u>Edward Lynch</u>	14. MOTHER'S MAIDEN NAME <u>MARY FyLNN</u>
------------------------------------------	-----------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Dorothy Stasulli</u> Address <u>3267 Mt. Rainier Rd</u>
---------------------------------------------------------------------------------	--------------------------------------	-----------------------------------------------------------------------------

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertension</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
----------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------	--------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------	--------------------------------------

21. I certify that I attended the deceased from <u>Sept 1, 1957</u> to <u>Oct 13, 1958</u> , that I last saw the deceased alive on <u>Oct 11, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>35-744 Ave NE, 10/13/58</u>
ACTUAL SIGNATURE <u>Arthur L. Brady</u> M.D.	PHYSICIAN'S NAME (Type)	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rainier</u>	22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>Wash. D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 15 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11618

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. KELLY		MALE		35		JAN 15 1883		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
100 N. BOSTON ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JAN 20 1918		10:00 AM		10:00 AM		100.0		100	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. J. KELLY		J. J. KELLY		J. J. KELLY		J. J. KELLY		J. J. KELLY	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JAN 20 1918		10:00 AM		10:00 AM		100.0		100	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G234 10-14-58 et

11688

## CERTIFICATE OF DEATH

Reg. Dist. No.

11650

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quincy - Lutham, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quincy - Lutham, Md</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4765 West Ave Oak Knoll</b>				e. STREET ADDRESS <b>4765 West Ave Oak Knoll</b>			
3. NAME OF DECEASED (Type or print) First <b>HANNAH</b> Middle <b>V</b> Last <b>LYNN</b>				4. DATE OF DEATH Month <b>10</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 22 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Mr Dennis Long</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>579-01-9596</b>		17. INFORMANT <b>Harvey Lynn - son</b> Address <b>4765 West Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Heart Disease</b> DUE TO (c) <b>General Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 24, 1958</b> , to <b>Oct 6, 1958</b> , that I last saw the deceased alive on <b>Oct 6, 1958</b> , and that death occurred at <b>4:05 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Paul C. Van Natta</b> M.D. <b>5480 Silver Hill Rd SE</b>							
PHYSICIAN'S NAME (Type) <b>PAUL C. VAN NATTA</b> <b>WASHINGTON 28 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-9-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Regis A. Nash</b> ADDRESS <b>741-11th St. S.E. Wash. D.C.</b>				24. REC'D BY REGISTRAR <b>OCT 8 58</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Glen Linden</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Gen. Hosp</i>			d. STREET ADDRESS <i>Geo Palmer &amp; Glen Linden</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Annice Ford Mahoney</i>			4. DATE OF DEATH Month <i>October</i> Day <i>1</i> Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Benjamin Ford</i>			14. MOTHER'S MAIDEN NAME <i>Nellie Barnes</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Benjamin Ford - Wash, D.C.</i> Address <i>5401 - Bell Place</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Cardiovascular renal disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular renal disease</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Mahoney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>JOHN T. MALONEY, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>10-1-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-4-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Washington, D. C.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhines &amp; Co.</i>		ADDRESS <i>3015 12th St., NE</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 6 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

1-20-28

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1-20-28

DATE OF DEATH

*[Faint, mostly illegible handwritten text in the upper section of the form, likely containing patient information and details of the death.]*

*[Faint, mostly illegible handwritten text in the middle section of the form, likely containing medical history and cause of death.]*

*[Faint, mostly illegible handwritten text in the lower section of the form, likely containing signatures and official stamps.]*

11652

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRWIN INGRAHAM MAIN</u>				4. DATE OF DEATH <u>October 4 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Driving</u>		11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ramon L. Main</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Liven</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-34-5907</u>		17. INFORMANT <u>Mr J. Main - 6828 Roosevelt Ave, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CVA Disease</u> DUE TO <u>Diabetes Mellitus</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u> <u>10 years</u> <u>10 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1970</u> , to <u>Oct 4, 1958</u> , that I last saw the deceased alive on <u>Oct 3, 1958</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ</u>				DATE SIGNED <u>10/4/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ADDISON CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SEAT Pleasant R 600 Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>				ADDRESS <u>5801 Clive Ave, Riverdale Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christ S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

—

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11653

## CERTIFICATE OF DEATH

11654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>4 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rogers Heights</b> d. STREET ADDRESS <b>5026-56th Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>McGinn</b> Last <b>McGinn</b>		4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Navy Yard, Wash. DC.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cornwall, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Patrick McGinn</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McAleer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Spanish Amer.</b>		16. SOCIAL SECURITY NO. <b>18-19-1905</b>	
17. INFORMANT <b>Mary Catherine McGinn</b>		Address <b>above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>congestive heart failure</b> DUE TO (c) <b>arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>58</b> , to <b>Oct 15/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 15/58</b> , 19 <b>58</b> , and that death occurred at <b>11:30A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. H. Bergemann</b>		ADDRESS (Street, city or town, state) <b>2724-74th AVENUE</b>	
PHYSICIAN'S NAME (Type) <b>Dr. TILL BERGEMANN</b>		DATE SIGNED <b>HYATTSVILLE, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home, Inc.</b>		ADDRESS <b>Mt. Rainier, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11651

11650 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 x 5706 Cheverly</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Joseph</b> Last <b>McHugh</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Nov 1906</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor, Ins. Claims Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Kingston, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Joseph McHugh</b>		14. MOTHER'S MAIDEN NAME <b>Mary McManus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>W.W.# 2</b>		16. SOCIAL SECURITY NO. <b>211-10-0759</b>	
17. INFORMANT <b>Edna Arlene McHugh</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Obstruction to the Ant. descending branch to the left. Cor. Artery</b> (c) <b>branch to the left. Cor. Artery</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/25</b> , 19 <b>58</b> , to <b>10/26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/25/58</b> , 19 <b>58</b> , and that death occurred at <b>3 45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Kauffman</b>		ADDRESS (Street, city or town, state) <b>5102 Annapolis Road, Arlington, Va.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. J. Kauffman, M., D</b>		DATE SIGNED <b>10/26/58</b>	
22a. BURIAL, CREMATION, or REMOVAL <b>burial</b>		22b. DATE THEREOF <b>10/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		ADDRESS <b>Wash, D.C.</b>	
24a. REC'D BY REGISTRAR <b>OCT 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11608 CERTIFICATE OF DEATH

Reg. Dist. No. 11655

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b>		c. LENGTH OF STAY IN 1b <b>15</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5309 38th ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Hazen MC Leod</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Mc Leod</b>		14. MOTHER'S MAIDEN NAME <b>Christine Monroe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Minnie C Mc Leod</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X Pul Tuberculosis</b> DUE TO (b) <b>Ca. Prostat.</b> DUE TO (c) <b>?</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>q. m.</b> 19 <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>57</b> , to <b>Oct 29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 28</b> , 19 <b>58</b> , and that death occurred at <b>4:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1801 Eye St. N.W. Washington D.C.</b> DATE SIGNED <b>Oct 29</b>			
ACTUAL SIGNATURE <b>E.R. Fenton</b>		PHYSICIAN'S NAME (Type) <b>E. RAYMOND FENTON</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/1/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

11602

MAINTAIN STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

MAINTAIN  
STATE DEPARTMENT OF HEALTH  
BALTIMORE, MD

MAINTAIN  
STATE DEPARTMENT OF HEALTH  
BALTIMORE, MD

<p>1. Name of deceased (Print or type full name)                  _____</p>	
<p>2. Sex (Male or Female)                  _____</p>	
<p>3. Date of birth (Month, day, year)                  _____</p>	
<p>4. Place of birth (City, State, Country)                  _____</p>	
<p>5. Date of death (Month, day, year)                  _____</p>	
<p>6. Place of death (City, State, Country)                  _____</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause)                  _____                  _____                  _____</p>	
<p>8. Signature of physician (Print name and sign)                  _____</p>	
<p>9. Signature of registrar (Print name and sign)                  _____</p>	
<p>10. Signature of informant (Print name and sign)                  _____</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11656**

**11689**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bechtel T. Homes</u> 5 weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7263 L Street</u>			d. STREET ADDRESS <u>1818-5th Street NW</u>		
3. NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>McWain</u> Middle <u>McWain</u> Last <u>McWain</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 18, 1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>bus Home</u>		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>James I. Boyd</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Oct 5, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 8, 1958</u>		22b. DATE THEREOF <u>Oct 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
22d. LOCATION (City, town, or county) <u>Washington D.C.</u>		22e. (State) _____		22f. (Country) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amrose D. Boyd</u>			24a. REC'D BY REGISTRAR <u>OCT 7 '58</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			24c. (City or town) _____		



11690

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4658 CEDAR RIDGE DR.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ORAM (LARAMY) MEAKER</u>		4. DATE OF DEATH Month Day Year <u>OCT. 3 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CATASAUQUA PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LARAMY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANN McDANIEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SISTERS</u>		Address <u>MARGARET L. MEAKER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260x</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>2 yr</u> <u>8 yr -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mel - Cerebral Sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>10-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>58</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Myrtle Post Baker</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1635 HARVARD ST.</u>	
PHYSICIAN'S NAME (Type) <u>WYRTT POST BAKER</u>		<u>WASHINGTON D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>10-3-58</u>	<u>NISKY HILL CEM.</u>	<u>BETHLEHEM, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee</u>		ADDRESS <u>300 4th ST. N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11691

## CERTIFICATE OF DEATH

Reg. Dist. No.

11658

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradbury Heights</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4815 W. St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>(MOORE) MARTHA JANE MOORE</i>		4. DATE OF DEATH Month Day Year <i>Oct 14 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 14, 1883</i>
9. AGE (In years last birthday) <i>75 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Chandler</i>		14. MOTHER'S MAIDEN NAME <i>Katy Ann Stedham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Frankie Jordan</i>		Address <i>9506 Waverly Dr. Seabrook Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Arterio Sclerosis</i> DUE TO (c) <i>Generalized Arterio Sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had 2 coronary infarctions (ECG) within past year.</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/27</i> , 19 <i>58</i> , to <i>10/14</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/22</i> , 19 <i>58</i> , and that death occurred at <i>2:20 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas F. Cullen</i>		ADDRESS (Street, city or town, state) <i>4400 Brown Road, S.E., D.C.</i> DATE SIGNED <i>10/14/58</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS F. CULLEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-17-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co. Washington, D. C.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11619

## CERTIFICATE OF DEATH

11659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Rainier about 35 yrs Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3423 Eastern Ave.</u>		d. STREET ADDRESS <u>3423 Eastern Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>JOSEPH</u> Middle <u>MORGAN</u> Last		4. DATE OF DEATH <u>OCT</u> Month <u>14</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1884</u> 9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Plumbing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>Chester, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>179-12-7087</u>	
17. INFORMANT <u>E. Bernice Barnes</u> Address <u>above</u>		<u>Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Second Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1948</u> to <u>10/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>58</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.S. Williams</u> M.D. <u>35 New York Ave. NW</u>		DATE SIGNED <u>10/21/58</u>	
PHYSICIAN'S NAME (Type) <u>R.S. WILLIAMS</u>		<u>35 NEW YORK AVE. NW</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/18/58</u>	<u>Fork Lincoln</u>	<u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Jan 15 1924</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>	
SINGLE		MARRIED		WIDOWED	
DIVORCED		SEPARATED		OTHER	
DATE OF MARRIAGE <i>Jan 1 1915</i>		PLACE OF MARRIAGE <i>St. Paul's Church</i>		CITY <i>Baltimore</i>	
NAME OF WIFE <i>Jane Doe</i>		NAME OF HUSBAND <i>John Doe</i>		NAME OF CHILD <i>John Doe</i>	
DATE OF BIRTH <i>Jan 1 1879</i>		PLACE OF BIRTH <i>England</i>		CITY <i>Baltimore</i>	
NAME OF FATHER <i>John Doe</i>		NAME OF MOTHER <i>Jane Doe</i>		NAME OF GRANDFATHER <i>John Doe</i>	
DATE OF DEATH <i>Jan 15 1924</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>	
SINGLE		MARRIED		WIDOWED	
DIVORCED		SEPARATED		OTHER	
DATE OF MARRIAGE <i>Jan 1 1915</i>		PLACE OF MARRIAGE <i>St. Paul's Church</i>		CITY <i>Baltimore</i>	
NAME OF WIFE <i>Jane Doe</i>		NAME OF HUSBAND <i>John Doe</i>		NAME OF CHILD <i>John Doe</i>	
DATE OF BIRTH <i>Jan 1 1879</i>		PLACE OF BIRTH <i>England</i>		CITY <i>Baltimore</i>	
NAME OF FATHER <i>John Doe</i>		NAME OF MOTHER <i>Jane Doe</i>		NAME OF GRANDFATHER <i>John Doe</i>	

RECEIVED BY THE CLERK OF THE BOARD OF HEALTH OF BALTIMORE, MD. JAN 15 1924

1  
Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11692

## CERTIFICATE OF DEATH

Reg. Dist. No.

11660

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 4404 Ord St., N. E.					
3. NAME OF DECEASED (Type or print) First Middle Last Henley - Nelson				4. DATE OF DEATH Month Day Year 10 27 19 58					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/17/05			
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver				10b. KIND OF BUSINESS OR INDUSTRY Self-employed				11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Jack C. Nelson				14. MOTHER'S MAIDEN NAME Ella Ash					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 711-12-3258				17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung, with metastasis to both lungs, ribs, and left pleura. 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26/19 58, to 10/27, 19 58, that I last saw the deceased alive on 10/27/ 19 58, and that death occurred at 6:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital 10/27/58 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or County) (State)			
Removal		10/29/58		Church cemetery		Charlotte North Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Crouch				ADDRESS 51-R Street Apt				24a. REC'D BY REGISTRAR DATE OCT 31 '58	
								24b. REGISTRAR'S SIGNATURE Arthur S. Haus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11654

## CERTIFICATE OF DEATH

11661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>9 1/2 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Newman</b>		4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1958</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>United States</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Swann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth Swann</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primaturity</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 10, 19 58</b> to <b>October 10, 19 58</b> , that I last saw the deceased alive on <b>October 10, 19 58</b> , and that death occurred at <b>7:30P M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>		DATE SIGNED <b>10/13/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>10/16/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		ADDRESS <b>Administrator.</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2077308XVI



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11609

## CERTIFICATE OF DEATH

11662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4213 Oglethorpe St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edna Lyell Omohundro				4. DATE OF DEATH Month Day Year October 30, 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 3, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Henry E Lyell				14. MOTHER'S MAIDEN NAME Martha Jeffries			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Audrey Little Hyattsville Md.			
17. INFORMANT Audrey Little Hyattsville Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral-vascular accident with hemorrhage</u> DUE TO (c) <u>severe laceration of aorta</u>							INTERVAL BETWEEN ONSET AND DEATH 14 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>severe chronic ulcer</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1st, 1958, to Oct 30th, 1958, that I last saw the deceased alive on Oct 30th, 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Till Bergemann</u>				ADDRESS (Street, city or town, state) DATE SIGNED 4314 Gallatin Ave Hyattsville Md			
PHYSICIAN'S NAME (Type) <u>Till BERGEMANN</u>				M.D. <u>Mary Ann Ol</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov 2, 1958		Farnham Cemetery		Farnham Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARRIED		SINGLE	
OCCUPATION		EDUCATION	
PLACE OF BIRTH		CITY OF RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

WIMBOND



11655

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>38</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. STREET ADDRESS <b>2713 Bellevue Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Pearl Perkins</b>				4. DATE OF DEATH Month Day Year <b>October 6 19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 1, 1871</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jacob P Woods</b>				14. MOTHER'S MAIDEN NAME <b>Helen Darr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John B Perkins</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>6 mos</b> <b>5 years</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 15, 1958</b> to <b>Oct. 6, 1958</b> , that I last saw the deceased alive on <b>Oct. 6, 1958</b> and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman D. Comeau</b>				ADDRESS (Street, city or town, state) <b>3503 Perry St.</b>		DATE SIGNED <b>10/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau</b>				M.D. <b>MT Rainier Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11664

11693

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Airport Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L.</u> Last <u>Rawlings</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Robert Rawlings</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Annette Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mildred S. Rawlings</u> Address <u>Rt. #1, Box 246 Brandywine, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous anemia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Spinal cord pathology</u> (c) <u>Cancer of Prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>10-31</u> , 19 <u>58</u> that I last saw the deceased alive on <u>10-31</u> , 19 <u>58</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard W. Dobson</u> M.D.				DATE SIGNED <u>Brandywine, Md 10-2-58</u>			
PHYSICIAN'S NAME (Type) <u>Richard W. Dobson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookfield Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Naylor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

CERTIFICATE OF DEATH

Reg. Dist. No.

11665

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> c. LENGTH OF STAY IN b <b>11 mos.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>1011 UPSHUR ST., N.E.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b> d. STREET ADDRESS <b>WASHINGTON, D.C.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>REITH</b> Last <b>REITH</b>				4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/79</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORING</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN REITH</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-10-7845</b>		17. INFORMANT <b>Sister M. Jean Thorne - Carroll Manor</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cardiac Vascular Reflaxo</b> <b>442x</b> DUE TO <b>Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>10</b> Day <b>24</b> Year <b>1958</b> Hour a. m. <b>20</b> p. m. <b>00</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>55N Y Ave NW Wash DC</b>	
20f. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State) <b>D.C.</b>				20g. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State) <b>D.C.</b>			
21. I certify that I attended the deceased from <b>19 Oct 1958</b> to <b>20 Oct 1958</b> , that I last saw the deceased alive on <b>19 Oct 1958</b> , and that death occurred at <b>12 noon</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert C. Haile</b>				DATE SIGNED <b>10/20/58</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT C. HAILE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery, Wash. D.C.</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Mt Rainier, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>	

CERTIFICATE OF DEATH

11640

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 31		DATE OF BIRTH 11/11/1911		PLACE OF BIRTH Baltimore, Md.		RACE White	
MARITAL STATUS Single		OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:15 AM	
DATE OF DEATH 11/11/1942		TIME OF DEATH 10:15 AM		PLACE OF DEATH Baltimore, Md.		MANNER OF DEATH Natural		CAUSE OF DEATH Myocardial Infarction		SEX Male	
NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 31		DATE OF BIRTH 11/11/1911		PLACE OF BIRTH Baltimore, Md.		RACE White	
MARITAL STATUS Single		OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:15 AM	
DATE OF DEATH 11/11/1942		TIME OF DEATH 10:15 AM		PLACE OF DEATH Baltimore, Md.		MANNER OF DEATH Natural		CAUSE OF DEATH Myocardial Infarction		SEX Male	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11656

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> <input checked="" type="checkbox"/> <b>Seat Pleasant</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>6910 George Palmer Highway</b>	
3. NAME OF DECEASED (Type or print) <b>Jennie Domenica Romersa</b>		4. DATE OF DEATH <b>October 26 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/17/90</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Pietro Guiliere</b>		14. MOTHER'S MAIDEN NAME <b>Louise Veronica</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Joseph Romersa,</b>		<b>3110 Rittenhouse N.W. Washington, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>October 27, 1958</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-30-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 29 '58</b>	
ADDRESS <b>517-11th St. S.E.</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Marital Status		Religion		Race	
Date of Birth		Place of Birth		Country of Birth	
Date of Admission		Date of Discharge		Date of Death	
Date of Autopsy		Date of Examination		Date of Certification	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Signature		Date of Signature		Date of Signature	

11657

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Morris Rosenberg</b>				4. DATE OF DEATH <b>October 3 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/14/17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>41</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>ABRAHAM ROSENBERG</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>217-05-4848</b>			
17. INFORMANT <b>Helen Rosenberg</b>				Address <b>Address Same</b> <b>Wife</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) <b>4 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 1952</b> to <b>Oct. 3 1958</b> , that I last saw the deceased alive on <b>October 3 1958</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Smith. Prooque</b>				DATE SIGNED <b>3101 Arundel Rd. 10-3-58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Irving Grassgreen</b>				DATE SIGNED <b>Oct 6 1958</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10/6/58</b>		<b>ARK. NAT'L Cem.</b>		<b>ARK. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Belberg Funeral Home</b>				ADDRESS <b>4217-9th Ave.</b>		24a. REC'D BY REGISTRAR <b>Oct 6 1958</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11694

## CERTIFICATE OF DEATH

11668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b>				c. LENGTH OF STAY IN 1b <b>1 Year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton, Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>C.</b> Last <b>SCHAEFER</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>11th</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31- 1870</b>		9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Lydia Schaefer Same As # 2.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostate obstruction</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 10, 1958</b> , to <b>Oct 11, 1958</b> , that I last saw the deceased alive on <b>Oct 10, 1958</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James T. Boyd</b> M.D.				ADDRESS (Street, city or town, state) <b>8200 Marlboro Pike SE, Wash DC 20008</b>			
PHYSICIAN'S NAME (Type) <b>JAMES T. BOYD</b>				DATE SIGNED <b>Oct 11 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 14- 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 14 58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>	

This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of the Census, Department of Commerce, Washington, D. C., and that the same is a true and correct copy of the original as the same appears in the files of the Bureau of the Census, Department of Commerce, Washington, D. C.

# CERTIFICATE OF DEATH

PLACE OF BIRTH Maryland, Baltimore		MARITAL STATUS Single	
DATE OF BIRTH May 1, 1900		SEX Male	
PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
DATE OF DEATH May 1, 1900		TIME OF DEATH 10:00 AM	
PLACE OF INTERMENT Mount Vernon Cemetery		NAME OF CLERGYMAN Rev. J. M. Smith	
NAME OF DECEASED John Doe		NAME OF NEXT OF KIN John Doe	
ADDRESS OF DECEASED 123 Main St, Baltimore, Md.		ADDRESS OF NEXT OF KIN 123 Main St, Baltimore, Md.	
OCCUPATION OF DECEASED Clerk		OCCUPATION OF NEXT OF KIN Clerk	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF NEXT OF KIN John Doe	
SIGNATURE OF CLERGYMAN Rev. J. M. Smith		SIGNATURE OF REGISTRAR J. M. Smith	
SIGNATURE OF WITNESS J. M. Smith		SIGNATURE OF WITNESS J. M. Smith	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11658 CERTIFICATE OF DEATH

11669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly, Md</b> c. LENGTH OF STAY IN 1b <b>35 Minute</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George Co</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> d. STREET ADDRESS <b>7739 Annapolis Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>J</b> Last <b>Seifert</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/04</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Yard Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Arthur Seifert</b>		14. MOTHER'S MAIDEN NAME <b>Labbara Full</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Beatrice M Seifert Lanham, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Multiple pulmonary infarcts</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <b>Occlusion of left coronary artery with myocardial infarction.</b> DUE TO (c). <b>Coronary arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>1 week</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9/30</b> , 19 <b>58</b> , to <b>10/7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/7/58</b> , 19 <b>58</b> , and that death occurred at <b>5:35 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>10/7/58</b>	
PHYSICIAN'S NAME (Type) <b>W. Anderson H. Hs, Md.</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11695

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs Washington 25, D. C.</b> c. LENGTH OF STAY IN 1b <b>47X-3</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania D. C. MARYLAND</b> b. COUNTY <b>Ellwood City Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7000th Street 3737 Horner Place</b> d. STREET ADDRESS <b>SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Newborn</b> Middle <b>Sharketti</b> Last <b>Sharketti</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 October 1958</b>
9. AGE (In years lost birthday) yrs. <b>27</b>		10. IF UNDER 1 YEAR: Months <b>40</b> Days <b>27</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Sharketti</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Louise Fernald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John L Sharketti 3737 Horner Pl., Wash 20, D C</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal Anoxia</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) <b>Pre-eclampsia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>27 hours</b>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>7 October</b> , 19 <b>58</b> , to <b>7 October</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7 October</b> , 19 <b>58</b> , and that death occurred at <b>5:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Oct 58</b> DATE SIGNED ACTUAL SIGNATURE <b>Marvin S. Eiger</b> M.D. <b>USAF Hospital Andrews, Andrews AFB, Wash D C</b> PHYSICIAN'S NAME (Type) <b>MARVIN S EIGER CAPT USAF (MC)</b> <b>USAF Hospital Andrews, Andrews AFB, Wash D C</b>	
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>OCT. 13, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi's Funeral Home, Washington D. C.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

2050181XVI



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File G274 10-16-58 et

## CERTIFICATE OF DEATH

11696

Reg. Dist. No.

11671

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7703-Juneau St.</u>				d. STREET ADDRESS <u>17403-Juneau St.</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>Alma</u> Middle <u>Sharper</u> Last				4. DATE OF DEATH <u>10-16-1958</u> Month <u>10</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1887</u> 1887	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Smith</u>				14. MOTHER'S M maiden name <u>Helen Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>William F. Sharper</u>		Address <u>7703-Juneau St. Dist. Heights Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u>heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1, 1958</u> to <u>Oct 10, 1958</u> , that I last saw the deceased alive on <u>Oct 4, 1958</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2210 hills ave SE</u> DATE SIGNED <u>W. W. Chamberlain</u>							
ACTUAL SIGNATURE <u>John B Fegan</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN B FEGAN</u> <u>Wood MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlain</u> ADDRESS <u>577-11 St. SE</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 14 1958</u>							

11073

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>65</b>	
4. DATE OF DEATH <b>10-15-1968</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF BIRTH <b>NEW YORK</b>	
10. OCCUPATION <b>CLERK</b>		11. EDUCATION <b>HIGH SCHOOL</b>		12. RELIGION <b>CATHOLIC</b>	
13. MARITAL STATUS <b>MARRIED</b>		14. NUMBER OF SPOUSE <b>1</b>		15. NUMBER OF CHILDREN <b>3</b>	
16. NAME OF SPOUSE <b>MARY J. BROWN</b>		17. NAME OF CHILDREN <b>JOHN J. BROWN JR., MARY J. BROWN, ROBERT J. BROWN</b>		18. NAME OF NEXT OF KIN <b>JOHN J. BROWN JR.</b>	
19. NAME OF PHYSICIAN <b>DR. J. J. SMITH</b>		20. NAME OF HOSPITAL <b>ST. JOSEPH'S HOSPITAL</b>		21. NAME OF BURIAL PLACE <b>ST. JOSEPH'S CEMETERY</b>	
22. NAME OF FUNERAL HOME <b>JOHN J. BROWN &amp; SONS</b>		23. NAME OF CEMETERY <b>ST. JOSEPH'S CEMETERY</b>		24. NAME OF MINISTER <b>FR. J. J. SMITH</b>	
25. NAME OF CLERGYMAN <b>FR. J. J. SMITH</b>		26. NAME OF CHURCH <b>ST. JOSEPH'S CHURCH</b>		27. NAME OF PRIEST <b>FR. J. J. SMITH</b>	
28. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		29. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		30. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
31. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		32. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		33. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
34. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		35. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		36. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
37. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		38. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		39. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
40. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		41. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		42. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
43. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		44. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		45. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
46. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		47. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		48. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
49. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		50. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		51. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
52. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		53. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		54. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
55. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		56. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		57. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
58. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		59. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		60. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
61. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		62. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		63. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
64. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		65. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		66. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
67. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		68. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		69. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
70. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		71. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		72. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
73. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		74. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		75. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
76. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		77. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		78. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
79. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		80. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		81. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
82. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		83. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		84. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
85. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		86. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		87. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
88. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		89. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		90. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
91. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		92. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		93. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
94. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		95. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		96. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
97. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		98. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		99. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	
100. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		101. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>		102. NAME OF DECEASED'S SIGNATURE <b>JOHN J. BROWN</b>	

11073

11659

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>3 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General</b>			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Shelton</b> Last <b>Shelton</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Dec 08</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clark</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>Wm. J. Shelton</b>		14. MOTHER'S MAIDEN NAME <b>Hauldash ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 18 8857</b>		17. INFORMANT <b>Marion S. Shelton</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION (Post)</b> 420.0 DUE TO <b>Coronary-Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>April 19 57</b> to <b>10-30-58</b> , that I last saw the deceased alive on <b>10-30-58</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Albert Roth</b>		ADDRESS (Street, city or town, state) <b>PRINCE GEORGE MD</b>		DATE SIGNED <b>10-30-58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>10-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Edgemoor Crematory</b>	22d. LOCATION (City, town, or county)	(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Basch's Sons Hyattsville, Md</b>			24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11673

11660 Item 9 FilmG235 10-22-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> X <b>Oxen Hill Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>6175 St Barnabas Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>Simms</b> Last <b>Simms</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 14, 1958</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>21</b> Days <b>21</b>		IF UNDER 1 YEAR <b>1</b> IF UNDER 24 HRS. <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Rose Simms</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rose Simms</b> Address <b>Oxen Hill Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>October 5, 1958</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-8-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Methodist Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oxen Hill, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b> ADDRESS <b>3015 12th St., NE</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 8 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

FOR STATE  
HEALTH DEPT.

8

9

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. ...	
Sex		Male	
Age		...	
Date of Death		...	
Place of Death		...	
Cause of Death		...	
Manner of Death		...	
Signature of Medical Examiner		...	
Date of Certificate		...	

11697

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HEIGHTS, MD. 6 YRS</u>				c. LENGTH OF STAY IN 1b <u>X HILLCREST HEIGHTS, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 COLEBROOK DRIVE.</u>				d. STREET ADDRESS <u>5 COLEBROOK DRIVE</u>			
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>SMITH</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 13 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FREDRICKSBURG, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ARTHUR H. JENKINS</u>				14. MOTHER'S MAIDEN NAME <u>ADELIE INGRAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-28-9938</u>		17. INFORMANT <u>JOSEPH A. SMITH</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM &amp; sigmoid</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8-17-57</u> <u>TO 10-10-58</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-17-57</u> , 19____, to <u>10-10-58</u> , 19____, that I last saw the deceased alive on <u>9-26-58</u> , 19____, and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1400 BRANCH AVE, S.E.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Lawrence D. Summerfield, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>LAWRENCE D. SUMMERFIELD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	
22d. LOCATION (City, town, or county) <u>SUITLAND, MD.</u>				22e. NAME OF CEMETERY OR CREMATORY <u>SUITLAND, MD.</u>		22f. LOCATION (City, town, or county) <u>SUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>517 11th St. S.E.</u>		24a. REC'D BY REGISTRAR <u>DACT 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11661

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges Co</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5123 T Street</b> d. STREET ADDRESS <b>Bradbury Heights</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Teuran Smith</b>		4. DATE OF DEATH Month Day Year <b>October 11 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-8-03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry Business</b>	
13. FATHER'S NAME <b>Robert M. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Huskamp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ruby Smith Wife</b>		Address <b>Address Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pulmonary Edema</b> DUE TO (c) <b>Syphilitic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 2, 1958</b> , to <b>October 11, 1958</b> , that I last saw the deceased alive on <b>October 11, 1958</b> , and that death occurred at <b>10:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b>		ADDRESS (Street, city or town, state) <b>5432 Queens Chapel Rd</b>	
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER M.D.</b>		DATE SIGNED <b>10/11/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried Oct 14-58</b>		22b. DATE THEREOF <b>Oct 14-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Seneca, S.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seneca Bros</b>		ADDRESS <b>1661-9d Hope Rd S.C.</b>	
24a. REC'D BY REGISTRAR <b>ACT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

TAB. No. 1

Name of deceased		Age		Sex		Race		Religion		Marital status		Occupation		Cause of death		Place of death		Date of death		Time of death		Signature of physician		Signature of registrar		Signature of informant	
John Doe		45		Male		White		Roman Catholic		Married		Teacher		Heart disease		Home		Jan 15		10:00 AM		J. Smith		A. Jones		B. Brown	

11611

CERTIFICATE OF DEATH

11676

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	c. LENGTH OF STAY IN 1b <b>8 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOME</b>		d. STREET ADDRESS <b>5607 14th St. N.E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clementine Stinzing</b>		4. DATE OF DEATH Month Day Year <b>October 20, 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 17/68</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FREDERICK STINZING</b>		14. MOTHER'S MAIDEN NAME <b>MARY M. PFISTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>SACRED HEART HOME RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Coronary Thrombosis with Myocardial Infarction--</b> IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>5/11 57 to 10/20/ 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/11</b> , 19 <b>57</b> , to <b>10/20/ 58</b> , that I last saw the deceased alive on <b>10/18/ 58</b> , and that death occurred at <b>9:55 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F Collins</b>		ADDRESS (Street, city or town, state) <b>322 H Street, N.E.</b> DATE SIGNED <b>10/21/1958</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Collins, M.D.</b>		<b>Washington 2, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. REC'D BY REGISTRAR <b>Oct 23 '58</b>	
ADDRESS <b>WASH. D. C. 3821 14th. ST. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hahn</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11662

## CERTIFICATE OF DEATH

11677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Hr. 11 Min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oxon Hill, Washington 25, D. C.</b>	
		d. STREET ADDRESS <b>6708 Palmer Road</b>	
3. NAME OF DECEASED (Type or print) <b>Stocks Baby Boy</b>		4. DATE OF DEATH <b>Oct. 13, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. <b>3</b> <b>11</b> <b>11</b>	
10b. KIND OF BUSINESS OR INDUSTRY		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Yrs.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Stocks</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mother</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Atelectasis</b> <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 13 1958</b> 19 to <b>Oct 19, 1958</b> 19, that I last saw the deceased alive on <b>Oct. 13 1958</b> , and that death occurred at <b>10:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Perkins</b>		DATE SIGNED <b>10/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>10/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>Administrator.</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11612 CERTIFICATE OF DEATH

11678

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address). OR INSTITUTION <b>4706 Edmonston Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>R.</b> Last <b>Stombaugh</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1870</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ambrose Ritchey</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Hengst</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles E. Stombaugh Jr. Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerotic Heart Disease</b> DUE TO (c) <b>20 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>32 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19 <b>10-11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-2</b> , 19 <b>58</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert Roth</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>10-11-58</b>	
PHYSICIAN'S NAME (Type) <b>ALBERT ROTH</b>		<b>Riverdale Md.</b>	
22a. BURIAL, CREMATION, REMOVAL, OR TRANSPORTATION <b>90 / 11 / 58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>K. R. Miller F. H.</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 14 '58</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

11678

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING OR 10

CERTIFICATE OF DEATH

11612

<p>1. Name of deceased: <b>John Doe</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Age: <b>45 years</b></p>		<p>4. Date of death: <b>May 1, 1920</b></p>	
<p>5. Place of death: <b>Home</b></p>		<p>6. Cause of death: <b>Heart disease</b></p>	
<p>7. Signature of physician: <b>Dr. J. H. Smith</b></p>		<p>8. Signature of registrar: <b>John Doe</b></p>	
<p>9. Date of registration: <b>May 2, 1920</b></p>		<p>10. Place of registration: <b>City of New York</b></p>	
<p>11. Name of informant: <b>John Doe</b></p>		<p>12. Address of informant: <b>123 Main St.</b></p>	
<p>13. Name of informant: <b>John Doe</b></p>		<p>14. Address of informant: <b>123 Main St.</b></p>	
<p>15. Name of informant: <b>John Doe</b></p>		<p>16. Address of informant: <b>123 Main St.</b></p>	
<p>17. Name of informant: <b>John Doe</b></p>		<p>18. Address of informant: <b>123 Main St.</b></p>	
<p>19. Name of informant: <b>John Doe</b></p>		<p>20. Address of informant: <b>123 Main St.</b></p>	
<p>21. Name of informant: <b>John Doe</b></p>		<p>22. Address of informant: <b>123 Main St.</b></p>	
<p>23. Name of informant: <b>John Doe</b></p>		<p>24. Address of informant: <b>123 Main St.</b></p>	
<p>25. Name of informant: <b>John Doe</b></p>		<p>26. Address of informant: <b>123 Main St.</b></p>	
<p>27. Name of informant: <b>John Doe</b></p>		<p>28. Address of informant: <b>123 Main St.</b></p>	
<p>29. Name of informant: <b>John Doe</b></p>		<p>30. Address of informant: <b>123 Main St.</b></p>	
<p>31. Name of informant: <b>John Doe</b></p>		<p>32. Address of informant: <b>123 Main St.</b></p>	
<p>33. Name of informant: <b>John Doe</b></p>		<p>34. Address of informant: <b>123 Main St.</b></p>	
<p>35. Name of informant: <b>John Doe</b></p>		<p>36. Address of informant: <b>123 Main St.</b></p>	
<p>37. Name of informant: <b>John Doe</b></p>		<p>38. Address of informant: <b>123 Main St.</b></p>	
<p>39. Name of informant: <b>John Doe</b></p>		<p>40. Address of informant: <b>123 Main St.</b></p>	
<p>41. Name of informant: <b>John Doe</b></p>		<p>42. Address of informant: <b>123 Main St.</b></p>	
<p>43. Name of informant: <b>John Doe</b></p>		<p>44. Address of informant: <b>123 Main St.</b></p>	
<p>45. Name of informant: <b>John Doe</b></p>		<p>46. Address of informant: <b>123 Main St.</b></p>	
<p>47. Name of informant: <b>John Doe</b></p>		<p>48. Address of informant: <b>123 Main St.</b></p>	
<p>49. Name of informant: <b>John Doe</b></p>		<p>50. Address of informant: <b>123 Main St.</b></p>	
<p>51. Name of informant: <b>John Doe</b></p>		<p>52. Address of informant: <b>123 Main St.</b></p>	
<p>53. Name of informant: <b>John Doe</b></p>		<p>54. Address of informant: <b>123 Main St.</b></p>	
<p>55. Name of informant: <b>John Doe</b></p>		<p>56. Address of informant: <b>123 Main St.</b></p>	
<p>57. Name of informant: <b>John Doe</b></p>		<p>58. Address of informant: <b>123 Main St.</b></p>	
<p>59. Name of informant: <b>John Doe</b></p>		<p>60. Address of informant: <b>123 Main St.</b></p>	
<p>61. Name of informant: <b>John Doe</b></p>		<p>62. Address of informant: <b>123 Main St.</b></p>	
<p>63. Name of informant: <b>John Doe</b></p>		<p>64. Address of informant: <b>123 Main St.</b></p>	
<p>65. Name of informant: <b>John Doe</b></p>		<p>66. Address of informant: <b>123 Main St.</b></p>	
<p>67. Name of informant: <b>John Doe</b></p>		<p>68. Address of informant: <b>123 Main St.</b></p>	
<p>69. Name of informant: <b>John Doe</b></p>		<p>70. Address of informant: <b>123 Main St.</b></p>	
<p>71. Name of informant: <b>John Doe</b></p>		<p>72. Address of informant: <b>123 Main St.</b></p>	
<p>73. Name of informant: <b>John Doe</b></p>		<p>74. Address of informant: <b>123 Main St.</b></p>	
<p>75. Name of informant: <b>John Doe</b></p>		<p>76. Address of informant: <b>123 Main St.</b></p>	
<p>77. Name of informant: <b>John Doe</b></p>		<p>78. Address of informant: <b>123 Main St.</b></p>	
<p>79. Name of informant: <b>John Doe</b></p>		<p>80. Address of informant: <b>123 Main St.</b></p>	
<p>81. Name of informant: <b>John Doe</b></p>		<p>82. Address of informant: <b>123 Main St.</b></p>	
<p>83. Name of informant: <b>John Doe</b></p>		<p>84. Address of informant: <b>123 Main St.</b></p>	
<p>85. Name of informant: <b>John Doe</b></p>		<p>86. Address of informant: <b>123 Main St.</b></p>	
<p>87. Name of informant: <b>John Doe</b></p>		<p>88. Address of informant: <b>123 Main St.</b></p>	
<p>89. Name of informant: <b>John Doe</b></p>		<p>90. Address of informant: <b>123 Main St.</b></p>	
<p>91. Name of informant: <b>John Doe</b></p>		<p>92. Address of informant: <b>123 Main St.</b></p>	
<p>93. Name of informant: <b>John Doe</b></p>		<p>94. Address of informant: <b>123 Main St.</b></p>	
<p>95. Name of informant: <b>John Doe</b></p>		<p>96. Address of informant: <b>123 Main St.</b></p>	
<p>97. Name of informant: <b>John Doe</b></p>		<p>98. Address of informant: <b>123 Main St.</b></p>	
<p>99. Name of informant: <b>John Doe</b></p>		<p>100. Address of informant: <b>123 Main St.</b></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11663

## CERTIFICATE OF DEATH

11679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>13508-54<sup>th</sup> ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Stroup</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-71</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Stafford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Record office 4408 Queensbury Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 8</u> , 19 <u>58</u> to <u>Oct 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>58</u> , and that death occurred at <u>640</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>Oct 9, 1958</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin</u>				Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11664

## CERTIFICATE OF DEATH

11680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Suit</b>		4. DATE OF DEATH <b>October 19 19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/11/1884</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Parks</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Charles J Suit</b>		14. MOTHER'S MAIDEN NAME <b>Martha E Francis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 32 1038</b>	
17. INFORMANT <b>Evelyn Hoffmann</b> <b>Daughter</b> Address <b>Address Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>416X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO <b>rheumatic heart disease</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH 36 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-16</b> , 19 <b>58</b> to <b>10-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-19</b> , 19 <b>58</b> , and that death occurred at <b>3:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3717-38th Ave. Cottage City, Md.</b> DATE SIGNED <b>10-19-58</b>			
ACTUAL SIGNATURE <b>George Hageage</b> M.D. <b>3717-38th Ave.</b>		PHYSICIAN'S NAME (Type) <b>Dr. George Hageage</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11665

Reg. Dist. No. 11681

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITAL HEIGHTS</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITAL HEIGHTS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6116 59th AVE.</u>			d. STREET ADDRESS <u>1 6116 59th AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>PHILIP</u> Last <u>SULLIVAN</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6, 1898</u>		9. AGE (In years last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL GUN FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>EDWARD A. SULLIVAN</u>			14. MOTHER'S MAIDEN NAME <u>OWENS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ELIZABETH SULLIVAN</u> Address <u>6116 59th AVE. CAP. HGB, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Intra cranial hemorrhage</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct 15, 1958</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE  
OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		C		M		H		C		C		C		C	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM		OTHER	
JAN 15 1900		BALTIMORE		JAN 15 1945		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO		NO	
SIGNATURE OF EXAMINER		OFFICE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF DECEASED		OFFICE OF DECEASED		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JAMES H. HARRIS		BALTIMORE		JAN 15 1945		BALTIMORE		JAMES H. HARRIS		BALTIMORE		JAN 15 1945		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	

11698 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 22 DC</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6270 Allen Town Rd SE</u>		d. STREET ADDRESS <u>6270 Allen Town Rd SE DC</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lottie Josephine Taylor</u>		4. DATE OF DEATH Month Day Year <u>Oct 1 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince Georges Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Sweeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs Russel Padgett 6218 Allen Town Rd Washington 22 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u> <u>170X</u> DUE TO (b) <u>Carcinoma RT Breast with Metastases</u> DUE TO (c) <u>and General Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>1 year</u> <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 1958, to <u>Oct 1</u> , 1958, that I last saw the deceased alive on <u>Oct 1</u> , 1958, and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russel Padgett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Washington 22 DC 10/2/58</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATA</u>		<u>5440 Silver Hill Rd SE.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 4-58</u>	<u>Cedar Hill Cemetery</u>	<u>Smithland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Summers Bros 1661-94 Hyatt Rd SE Wash DC</u>		24a. RECEIVED BY REGISTRAR DATE <u>OCT 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White	
DATE OF DEATH April 15, 1952		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		FILE NO. 67890	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11699

## CERTIFICATE OF DEATH

Reg. Dist. No.

11683

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oxon Hill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5320 Oxon Hill Road</b>				d. STREET ADDRESS <b>5320 Oxon Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Walter</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Prince George County, Md.</b>	
13. FATHER'S NAME <b>Hugh Walter Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Briscoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>577 16 7317</b>		17. INFORMANT Address <b>Mrs. Mary Alice Thompson 5320 Oxon Hill Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.2 CARCINOMA OF LOWER BOWEL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10-3-58</b> , 19 <b>58</b> , to <b>10-7-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-3-58</b> , 19 <b>58</b> , and that death occurred at <b>3:40</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>D. C.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Theodore E. Corporew MD</b>				M.D. <b>2433 1/2 Nichols Ave., S. E. Wash.,</b>			
PHYSICIAN'S NAME (Type) <b>Theodore E. Corporew</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Church</b>		22d. LOCATION (City, town, or county) (State) <b>Oxon Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Mason</b>				ADDRESS <b>Home Inc Wash, D. C. 2500 Nichols Ave. S. E.</b>		24b. REGISTRAR'S SIGNATURE DATE	

## 1024

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pi-Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Penn-R-R-Tracto</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Milledge</u> First <u>Jillman</u> Middle Last		4. DATE OF DEATH <u>10-22-1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col-</u> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-1910</u>	9. AGE (In years last birthday) <u>48</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTH PLACE (State or foreign country) <u>So Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milledge Jillman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Dean Jillman; same address</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> 810X DUE TO (b) <u>Trauma—multiple and severe.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Operator an automobile struck by a train</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:40 a.m. 10-22-1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>P-R-Tracto</u>	20f. (City or town) <u>Bowie-Pi-Geo-Md.</u> (County) <u></u> (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>10-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln M.</u>		22d. LOCATION (City, town, or county) <u>Suitland Rd. Md.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall Bros</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>621 Fla. Ave NW</u>		DATE <u>OCT 24 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 show to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11666

## CERTIFICATE OF DEATH

Reg. Dist. No.

11685

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 1 3602 Perry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary		Middle L		Last Toffon	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 29, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Michael Mele		14. MOTHER'S MAIDEN NAME Michalina Scrivano		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-20-3039A	
17. INFORMANT Alfred Toffon		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA UTERUS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos 24 yrs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from July 1952 to Oct 30, 1958, that I last saw the deceased alive on Oct 30, 1958, and that death occurred at 8:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 3503 Perry St 10/30/58	
ACTUAL SIGNATURE Norman Donat Comeau		M.D.		PHYSICIAN'S NAME (Type) Norman Donat Comeau		MT Rainier Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

CERTIFICATE OF DEATH

11688

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1893		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1938		10:15 AM		10:15		10:15		10:15	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1938		JAN 20 1938		JAN 20 1938		JAN 20 1938		JAN 20 1938	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11686

11623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>Takoma Park</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>		d. STREET ADDRESS <b>404 Circle Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>404 Circle Avenue</b>		3. NAME OF DECEASED (Type or print) <b>Octavio Ricardo Torres</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1885</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Cuba</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Octavio R. Torres</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Garcia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Halene Putnam Jones; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>October 6, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Oct. 7, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
22d. LOCATION (City, town, or county) <b>Prince Georges County</b>		(State) <b>Md.</b>		24a. REC'D BY REGISTRAR <b>DCT 9 '58</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll St NW DC</b>		ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



• • • • •

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11687

Reg. Dist. No.

11667

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Phoebe Towers		4. DATE OF DEATH October 10 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1868 89y.
9. AGE (In years last birthday) 89y.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME George Washington Webster	
14. MOTHER'S MAIDEN NAME Eliza Price		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Frances Towers Williams, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 11, 1958	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 14th, 1958	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kramer	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11613

11688

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	c. LENGTH OF STAY IN 1b <b>9 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>832 Chillum Road</b>		d. STREET ADDRESS <b>832 Chillum Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>Trout</b> Middle Last		4. DATE OF DEATH <b>October 23, 1958</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk and inventory man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Un. of Md.</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Washington Trout</b>	
14. MOTHER'S MAIDEN NAME <b>Eda Sallwildo Paul</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>W.W.1 to 1931 577-09-2741</b>		17. INFORMANT <b>Edith Eunice Trout; same address.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> DUE TO <b>Acute congestive heart failure</b> IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovasculat renal disease</b> [a], stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John J. Maloney</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 24, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-27-58</b>	22b. DATE THEREOF <b>George Washington</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hyattsville Md</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Real Funeral Home</b>		24a. REC'D BY REGISTRAR <b>4812 24 Ave NW</b>	
ADDRESS <b>Wash DC</b>		24b. REGISTRAR'S SIGNATURE <b>DATE OCT 29 '58</b>	

MISSOURI STATE DEPARTMENT OF HEALTH - BARNHART  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11010

FILE NO. 11010  
DEPT. OF HEALTH

Place of death

St. Louis

Age

St. Louis

1221 Olive St.

1221 Olive St.

Married

Married

White

Sept. 6, 1902

Mr. Henry

Mr. Henry

George Washington

George Washington

11 to 12 1/2

11 to 12 1/2

Acute coronary artery failure

Coronary artery disease

11 to 12 1/2

11 to 12 1/2

11 to 12 1/2

11 to 12 1/2

October 21, 1902

John T. Barnhart

## 11614 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WASHINGTON, D.C.</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE GEORGES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>		d. STREET ADDRESS <b>5601 13th STREET, N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>ESTELLE</b> First Middle Last <b>WALSH</b>		4. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/90</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY HEARD</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET BALDWIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Sister M. Jean Thum - Carol Kern</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> <b>237x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Tumor, Diabetes mellitus, 50 years of age, generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mths - app.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>58</b> , to <b>Oct 23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 21</b> , 19 <b>58</b> , and that death occurred at <b>12:55 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Curtin</b>		ADDRESS (Street, city or town, state) <b>900 17th St N.W. Wash D.C.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>THOMAS E. CURTIN</b>		<b>900 17th STREET, N.W. WASHINGTON, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-25-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>mt Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. J. Collins</b> ADDRESS <b>3821-14-40</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 28 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11701

## CERTIFICATE OF DEATH

Reg. Dist. No.

11690

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>53 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 1 Box 390</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ROBERTS</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>OCT</u> , Day <u>15</u> , Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 29 1904</u> 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRISON C. WARD</u>		14. MOTHER'S M maiden name <u>LORENA ROBERTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-38-3889</u>	
17. INFORMANT <u>MARY WARD - RT 1 Box 387</u>		Address <u>CLINTON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CONGESTIVE HEART FAILURE</u> DUE TO <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>54 minutes</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> p.m. <u>None</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>58</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>BRANCH AVE. CLINTON, MD 19158</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		DATE SIGNED <u>2nd 10/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 18 - 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Bros.</u>		ADDRESS <u>1661-9th Hope</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	
DATE <u>OCT 17 '58</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. DECEASED AT MEMPHIS, TENN.		12. PLACE OF DEATH MEMPHIS, TENN.		13. DATE OF DEATH 4/4/68		14. TIME OF DEATH 10:00 PM		15. CAUSE OF DEATH MURDER	
16. MANNER OF DEATH Homicide		17. MEDICAL HISTORY None		18. PREVIOUS ILLNESS None		19. SURGICAL HISTORY None		20. MEDICATION None	
21. PHYSICIAN DR. J. H. HARRIS		22. HOSPITAL None		23. CORONER DR. J. H. HARRIS		24. MEDICAL EXAMINER DR. J. H. HARRIS		25. SIGNATURE OF PHYSICIAN J. H. HARRIS	
26. SIGNATURE OF CORONER J. H. HARRIS		27. SIGNATURE OF MEDICAL EXAMINER J. H. HARRIS		28. SIGNATURE OF DEATH REGISTRAR J. H. HARRIS		29. SIGNATURE OF COUNTY CLERK J. H. HARRIS		30. SIGNATURE OF STATE CLERK J. H. HARRIS	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the Medical Director; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11691

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly			c. LENGTH OF STAY IN 1b 7 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo's General Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Evelyn Trueman Watson			4. DATE OF DEATH October 6 19 58		
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-20-83		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry T. Trueman		14. MOTHER'S MAIDEN NAME E. Florence Deakens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No *****		16. SOCIAL SECURITY NO. 215-38-3659		17. INFORMANT 1802 Avalon Place, Stanley B. Watson; Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>Myocardial infarction</del> Cardiac arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular fibrillation (c) Hypertensive arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 954X INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cardiac arrest during anesthetic, partial recovery followed by death			
20c. TIME OF INJURY Month, Day, Year Hour p.m. 10-6 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Choverly		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/58		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	
22d. LOCATION (City, town, or county) Baden		22e. (State) Maryland.		22f. REC'D BY REGISTRAR DATE OCT 14 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		23a. REGISTRAR'S SIGNATURE Arthur S. Kraus		23b. REGISTRAR'S SIGNATURE	

2

2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON, 19

*[Faint, illegible text from bleed-through]*

☐ I have been contacted by a person who claims to be a representative of the FBI and has asked me to provide information regarding my activities. I have provided the information requested and have been told that the information will be used for the purpose of identifying and locating individuals who are involved in the activities of the FBI.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11669

## CERTIFICATE OF DEATH

11692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4824 48th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>L</b> Last <b>Weber</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 April 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary E Franke</b> Address <b>Edmonston Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b> <b>443 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13, 1958</b> , to <b>Oct 28, 1958</b> , that I last saw the deceased alive on <b>Oct 27, 1958</b> , and that death occurred at <b>12005AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Rosson MD</b>		ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>William Rosson, M.D.</b>		<b>Bladensburg, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11702

## CERTIFICATE OF DEATH

11693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>None</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews</b>				d. STREET ADDRESS <b>3421 21st Street S E</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Newborn</b> Middle <b>West</b> Last <b>West</b>		4. DATE OF DEATH		Month <b>October</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 October 1958</b>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Henry West Jr</b>				14. MOTHER'S MAIDEN NAME <b>Doloris Marie Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>John Henry West Jr</b> Address <b>3421 21st Street SE Wash D C</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>80 minutes</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>80 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8 October</b> , 19 <b>58</b> , to <b>8 October</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 October</b> , 19 <b>58</b> , and that death occurred at <b>1230 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Marvin S. Eiger</b> M.D. <b>USAF Hospital, Andrews AFB, Md.</b> <b>8 Oct 58</b>							
ACTUAL SIGNATURE <b>Marvin S. Eiger</b>							
PHYSICIAN'S NAME (Type) <b>MARVIN S EIGER CAPT USAF (MC)</b> <b>USAF Hospital, Andrews AFB, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery Arlington Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Palmer Funeral Home</b> <b>412 M St NE Wash D. C.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Christ S. Thoma</b>	

2050210XVO

11703

## CERTIFICATE OF DEATH

11703

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Author		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide by gunshot		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Room 936, Lorraine Hotel, Memphis, Tenn.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 10:15 AM	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN J. Edgar Hoover		19. SIGNATURE OF CLERK J. Edgar Hoover		20. SIGNATURE OF REGISTRAR J. Edgar Hoover	
21. SIGNATURE OF WITNESS J. Edgar Hoover		22. SIGNATURE OF WITNESS J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF WITNESS J. Edgar Hoover		25. SIGNATURE OF WITNESS J. Edgar Hoover	
26. SIGNATURE OF WITNESS J. Edgar Hoover		27. SIGNATURE OF WITNESS J. Edgar Hoover		28. SIGNATURE OF WITNESS J. Edgar Hoover		29. SIGNATURE OF WITNESS J. Edgar Hoover		30. SIGNATURE OF WITNESS J. Edgar Hoover	
31. SIGNATURE OF WITNESS J. Edgar Hoover		32. SIGNATURE OF WITNESS J. Edgar Hoover		33. SIGNATURE OF WITNESS J. Edgar Hoover		34. SIGNATURE OF WITNESS J. Edgar Hoover		35. SIGNATURE OF WITNESS J. Edgar Hoover	
36. SIGNATURE OF WITNESS J. Edgar Hoover		37. SIGNATURE OF WITNESS J. Edgar Hoover		38. SIGNATURE OF WITNESS J. Edgar Hoover		39. SIGNATURE OF WITNESS J. Edgar Hoover		40. SIGNATURE OF WITNESS J. Edgar Hoover	
41. SIGNATURE OF WITNESS J. Edgar Hoover		42. SIGNATURE OF WITNESS J. Edgar Hoover		43. SIGNATURE OF WITNESS J. Edgar Hoover		44. SIGNATURE OF WITNESS J. Edgar Hoover		45. SIGNATURE OF WITNESS J. Edgar Hoover	
46. SIGNATURE OF WITNESS J. Edgar Hoover		47. SIGNATURE OF WITNESS J. Edgar Hoover		48. SIGNATURE OF WITNESS J. Edgar Hoover		49. SIGNATURE OF WITNESS J. Edgar Hoover		50. SIGNATURE OF WITNESS J. Edgar Hoover	
51. SIGNATURE OF WITNESS J. Edgar Hoover		52. SIGNATURE OF WITNESS J. Edgar Hoover		53. SIGNATURE OF WITNESS J. Edgar Hoover		54. SIGNATURE OF WITNESS J. Edgar Hoover		55. SIGNATURE OF WITNESS J. Edgar Hoover	
56. SIGNATURE OF WITNESS J. Edgar Hoover		57. SIGNATURE OF WITNESS J. Edgar Hoover		58. SIGNATURE OF WITNESS J. Edgar Hoover		59. SIGNATURE OF WITNESS J. Edgar Hoover		60. SIGNATURE OF WITNESS J. Edgar Hoover	
61. SIGNATURE OF WITNESS J. Edgar Hoover		62. SIGNATURE OF WITNESS J. Edgar Hoover		63. SIGNATURE OF WITNESS J. Edgar Hoover		64. SIGNATURE OF WITNESS J. Edgar Hoover		65. SIGNATURE OF WITNESS J. Edgar Hoover	
66. SIGNATURE OF WITNESS J. Edgar Hoover		67. SIGNATURE OF WITNESS J. Edgar Hoover		68. SIGNATURE OF WITNESS J. Edgar Hoover		69. SIGNATURE OF WITNESS J. Edgar Hoover		70. SIGNATURE OF WITNESS J. Edgar Hoover	
71. SIGNATURE OF WITNESS J. Edgar Hoover		72. SIGNATURE OF WITNESS J. Edgar Hoover		73. SIGNATURE OF WITNESS J. Edgar Hoover		74. SIGNATURE OF WITNESS J. Edgar Hoover		75. SIGNATURE OF WITNESS J. Edgar Hoover	
76. SIGNATURE OF WITNESS J. Edgar Hoover		77. SIGNATURE OF WITNESS J. Edgar Hoover		78. SIGNATURE OF WITNESS J. Edgar Hoover		79. SIGNATURE OF WITNESS J. Edgar Hoover		80. SIGNATURE OF WITNESS J. Edgar Hoover	
81. SIGNATURE OF WITNESS J. Edgar Hoover		82. SIGNATURE OF WITNESS J. Edgar Hoover		83. SIGNATURE OF WITNESS J. Edgar Hoover		84. SIGNATURE OF WITNESS J. Edgar Hoover		85. SIGNATURE OF WITNESS J. Edgar Hoover	
86. SIGNATURE OF WITNESS J. Edgar Hoover		87. SIGNATURE OF WITNESS J. Edgar Hoover		88. SIGNATURE OF WITNESS J. Edgar Hoover		89. SIGNATURE OF WITNESS J. Edgar Hoover		90. SIGNATURE OF WITNESS J. Edgar Hoover	
91. SIGNATURE OF WITNESS J. Edgar Hoover		92. SIGNATURE OF WITNESS J. Edgar Hoover		93. SIGNATURE OF WITNESS J. Edgar Hoover		94. SIGNATURE OF WITNESS J. Edgar Hoover		95. SIGNATURE OF WITNESS J. Edgar Hoover	
96. SIGNATURE OF WITNESS J. Edgar Hoover		97. SIGNATURE OF WITNESS J. Edgar Hoover		98. SIGNATURE OF WITNESS J. Edgar Hoover		99. SIGNATURE OF WITNESS J. Edgar Hoover		100. SIGNATURE OF WITNESS J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G234, 10/10/58

## CERTIFICATE OF DEATH

11694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Laurel 41</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel 41</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Evans Bush Wils on</b>		4. DATE OF DEATH Month Day Year <b>October 1 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-97</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Howard Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Helena Snowden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>561.4</b> DUE TO <b>Renovated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Incarceration to the Cecum.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 1, 1958</b> , to <b>October 1, 1958</b> , that I last saw the deceased alive on <b>October 1, 1958</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Harold S. Tidler</b> M.D. <b>6480 NEW HAMPSHIRE AVE</b> PHYSICIAN'S NAME (Type) <b>TAKOMA PARK 12, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Bacontown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.L. Snowden</b>		ADDRESS <b>Rockville, Md</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	



## 11615 CERTIFICATE OF DEATH

Reg. Dist. No. 11695

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN TB <b>34 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4008 Jefferson Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>MACARTA</b> Last <b>YANCEY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29th</b> , Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29th, 1871</b>		9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Richardsville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Macarta Thornton</b>				14. MOTHER'S MAIDEN NAME <b>Sara Ann Hunt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>University Park, Md. Alfred R. Yancey, 4300 Tuckerman Street,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic leaflets</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 1, 1944</b> to <b>MAR 29, 1958</b> that I last saw the deceased alive on <b>MAR 29, 1958</b> , and that death occurred at <b>7:40 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4314 Gallatin Street, Hyattsville, Md.</b> DATE SIGNED <b>10/30/1958</b>							
ACTUAL SIGNATURE <b>A. Deitz</b>		M.D. <b>4314 Gallatin Street, Hyattsville, Md.</b>					
PHYSICIAN'S NAME (Type) <b>AARON DEITZ, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 1st, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Culpeper, Culpeper Co., Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		AGE 45		SEX Male		RACE White		DATE OF DEATH Jan 15, 1923		PLACE OF DEATH Home	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		BURIAL St. James Church	
FATHER'S NAME John H. Jones		MOTHER'S NAME Mary E. Jones		BIRTH DATE Jan 15, 1878		BIRTH PLACE Maryland		EDUCATION High School		OCCUPATION Farmer	
PREVIOUS MARRIAGE Yes		DATE OF MARRIAGE Jan 15, 1915		NAME OF SPOUSE Mary E. Jones		DATE OF DEATH OF SPOUSE None		REASON FOR DEATH Natural		OTHER INFORMATION None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None		SIGNATURE OF JURY None		SIGNATURE OF JUDGE None	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11696  
Reg. Dist. No.

11671

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>5408 O'Dell Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Edgar Murray Yates</b>			4. DATE OF DEATH Month <b>October</b> Day <b>21</b> , Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-10</b>		9. AGE (In years last birthday) <b>48</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Edgar Morray Yates</b>			14. MOTHER'S MAIDEN NAME <b>Euma H. Haswell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-2247</b>		17. INFORMANT <b>5501 Calvert Road Teresa Yates; College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carbon monoxide poisoning</b> (c), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Asphyxiated in automobile from exhaust fumes.</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>10-21-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Driveway of home</b>	20f. (City or town) <b>Beltsville, Pr. Geo.</b>	(County) <b>Md.</b>	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Maryland.</b>		
24a. REC'D BY REGISTRAR <b>OCT 24 '58</b>			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanks</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Honey, Jr.	
Sex		Male	
Age		35	
Date of Birth		10-21-28	
Place of Birth		Baltimore, Md.	
Usual Residence		Baltimore, Md.	
Cause of Death		Carbon monoxide poisoning	
Manner of Death		Accident	
Occupation		None	
Education		High School	
Marital Status		Married	
Spouse's Name		Mary T. Honey	
Spouse's Address		1001 N. Broadway, Baltimore, Md.	
Date of Death		October 21, 1958	
Time of Death		10:00 AM	
Place of Death		Home	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	